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STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
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August 29, 2017

Ms. Heather Ross
Project Officer
Division of State Demonstration Group
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Ms. Ross:

RE: AMENDMENT TO THE HAWAII QUEST EXPANDED MEDICAID SECTION 1115 DEMONSTRATION (11-W-00001/9)

The Hawaii Department of Human Services (DHS) requests approval of an amendment to the QUEST Expanded Section 1115 demonstration project to provide supportive housing services under the Medicaid program for qualified beneficiaries who meet the definition of being chronically homeless and who also have a behavioral or physical illness or a substance abuse diagnosis. Supportive housing services include Pre-Tenancy and Tenancy support services which include but are not limited to:

Pre-Tenancy Support

- Screening and Assessments
- Development of a housing support plan
- Assistance with housing search
- Application preparation and submission
- Moving assistance

Tenancy Support

- Individual housing and tenancy sustaining services
- Education and training, teach tenant responsibilities
- Teach dispute resolution with landlords and neighbors
- Service care coordination
- Job skills training and employment activities

AN EQUAL OPPORTUNITY AGENCY

These amendments will require changes to the demonstration's Special Terms and Conditions. Enclosed are redline versions of the demonstration document that incorporate the requisite changes.

As requested by the Centers for Medicare & Medicaid Services in proposing these amendments, the State based its public notice, the tribal consultation and input processes as described in 42 C.F.R. §431.408. The State published a public notice document (enclosed) on the DHS websites and in local papers and solicited public input during a 30-day comment period. No comments have been received to date.

The State solicited tribal consultation as described in the Medicaid State Plan on May 19, 2017 (enclosed). No comments have been received to date.

We request your favorable response at your earliest convenience. If you have any questions or would like to discuss this request, please contact Edie Mayeshiro, Medical Assistance Program Officer, at 808-692-8134.

Sincerely,

Pankaj Bhanot
Director

Enclosures

C: Judy Mohr Peterson, PhD, MQDA

short-term retroactive period due to catastrophic injury or illness, or persons who incur high medical expenses sporadically and thus will not meet their spend-down obligations every month.)

VI. BENEFITS

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

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

    b) **Alternative Benefit Plan[:].** The Affordable Care Act (ACA) New Adult Group will receive benefits provided through the state's approved alternative benefit plan (ABP) SPA. The VIII-like group will receive benefits that are identical to the benefits that will be included in the state's Medicaid State plan.

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

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

Service	Available for individuals who are assessed to be risk of deteriorating to institutional level of care	Available for individuals who meet institutional level of care ("1147 certified")
Adult day care	X*	X
Adult day health	X*	X
Assisted living facility		X
Community care foster family homes		X
Counseling and training		X
Environmental accessibility adaptations		X

Home delivered meals	X*	X
Home maintenance		X
Moving assistance		X
Non-medical transportation		X
Personal assistance	X	X
Personal emergency response system	X*	X
Residential care		X
Respite care		X
Skilled nursing	X	X
Specialized case management		X
Specialized medical equipment and supplies		X

* Denotes new services for the "At Risk" population under QUEST Integration.

ii. **Specialized Behavioral Health Services:** The services listed below (and further described in attachment E of the special terms and conditions) are available for individuals with serious mental illness (SMI), serious and persistent mental illness (SPMI), or requiring support for emotional and behavioral development (SEBD).
   1. Supportive Housing.
   2. Supportive Employment.
   3. Financial management services.

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

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

v. **Supportive Housing Services.** Services provided to qualified individuals who meet the criteria for and are in need of supportive housing services in order to obtain or remain permanent housing. Services shall be approved based on referrals.

[~~c)~~]d) **Cost of Room and Board Excluded from Capitation Rate Calculations.** For purposes of determining capitation rates, the cost of room and board is not included in non-institutional care costs.

[~~d)~~]e) **Community Participation.** The state, either directly or through its MCO contracts, will ensure that participants' engagement and community participation is supported and facilitated to the fullest extent desired by each participant.

[~~e)~~]f) **HCBS Standards.** The state will assure compliance with CMS standards for HCBS setting as articulated in current section 1915(c) and 1915(i) policy and as modified by subsequent regulatory changes.

[~~f)~~]g) **Managed Care Plan Change.** Beneficiaries may change managed care plans if their residential or employment support provider is no longer available through their current plan.

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

[~~h)~~]i) **Behavioral Health Benefits.** All QUEST Integration plans will provide a full array of standard behavioral health benefits (including substance abuse treatment) to members who may need such services. The state will also provide specialized behavioral health services to beneficiaries with SMI, SPMI, or requiring SEBD. The Behavioral Health Protocol address the following:

(i) Services provided by the DOH Child and Adolescent Mental Health Division (CAMHD) to children with serious emotional behavioral disorder (SEBD).
(ii) Services provided to adults with SMI or SPMI by the DOH Adult Mental Health Division (AMHD), the Med-QUEST division's Community Care Services (CCS) behavioral health program, or the contracted plans.
(iii) Reimbursement
(iv) A memorandum of agreement (MOA) that reflects the current interagency agreement for behavioral health services provided by the DOH to demonstration eligible.
(v) The process and protocol used for referral between MCOs and DOH or CCS, as well as the DOH or CCS and MCOs.

Any revisions to the QUEST Integration delivery system for Behavioral Health Services as defined in this sub-paragraph shall require a revision to Attachment E.

j) **Access to Supportive Housing Services.** To coordinate provision of supportive housing-related activities and services as appropriate with the goal of promoting community integration, optimal coordination of resources, and self-sufficiency for beneficiaries experiencing chronic homelessness who also have a disability, mental health condition, substance abuse disorder, or complex health needs. This will include outreach and engagement services, supported employment services, and other services identified as necessary to meet supportive housing goals for the beneficiary. The contracted MCO plans shall be responsible for ensuring eligible beneficiaries are provided the supportive housing services needed to secure and maintain permanent housing. Medicaid beneficiaries who meet the eligibility criteria described below shall be eligible for pre-tenancy and tenancy supportive housing services.

All Medicaid individuals eighteen (18) years of age or who are:

1. Chronically homeless under HUD definition;
2. Experiencing homelessness and has one of the qualifying health conditions listed below;
3. Living in an institution and cannot be discharged due to lack of stable housing and has one of the qualifying health conditions listed below; or

4. Living in public housing and at risk of eviction and has one of the qualifying health conditions listed below.

Qualifying Health Conditions:
- A mental health disorder which interferes with one or major life activities;
- Has been diagnosed with substance use disorder (SUD);
- Chronic physical or complex health needs; or
- Frequent emergency department/inpatient hospital use.

[i)]k **Functional Level of Care (LOC) Assessment.** Access to both institutional and HCBS long-term care services will be based on a functional LOC assessment to be performed by the contracted care plans or those with delegated authority. Individuals who meet the institutional level of care (NF, hospital) may access institutional care and/or HCBS through the contracted managed care plans. The contracted plans will be responsible for performing a functional assessment for each enrollee who is identified as having special health needs. The state's delegated contractor will review the assessments and make a determination as to whether the beneficiary meets an institutional (hospital or nursing facility) level of care. LOC assessments will be performed at least every twelve months (annual renewal) or more frequently, when there has been a significant change in the member's condition or circumstances.

[j)]l) **Access to Long-Term Care Services.** A key objective of the QUEST Integration demonstration is that beneficiaries meeting an institutional level of care shall have a choice of institutional services or HCBS. The HCBS provided must be person-centered and sufficient to meet the needs identified in the functional assessment, taking into account family and other supports available to the beneficiary. In order to move toward the objective of providing beneficiaries with a choice of services, the state must require the following from the contracted health plans:

i. If the individual has previously receive services under a Section 1915(c) waiver and continues to meet an institutional level of care, the individual must continue to receive HCBS appropriate to his or her needs. The services need not be identical to the ones previously received under the section 1915(c) waiver, by any change must be based upon the functional assessment and person-centered plan.

ii. For all other beneficiaries, if the estimated costs of providing necessary HCBS to the beneficiary are less than the estimated costs of providing necessary care in an institution (hospital or nursing facility), the plan must provide the HCBS to an individual who so chooses, subject to the limitation described in paragraph (c). Heath plans will be required to document good-faith efforts to establish a cost-effective, person-centered plan of care in the community using industry best practice and guidelines. If the estimated costs of providing necessary HCBS to the beneficiary exceed the estimated costs of providing necessary HCBS to the beneficiary exceed the estimated cost of providing necessary care in an institution (hospital or nursing facility), a plan may refuse to offer HCBS if the state or its independent oversight contractor so approves. In reviewing such a request, the state must take into account the plan's aggregate HCBS cost as compared to the aggregate costs that it would have paid for institutional care.

iii. A plan is not required to provide HCBS if the individual chooses institutional services, if he or she cannot safely served in the community, if there are not adequate

or appropriate providers for the services, or if there is an exceptional increase in the demand for HCBS. An exceptional increase in demand is defined as an increase beyond annual thresholds to be established by the state. In the case of exceptional increase, the state shall be responsible for monitoring any wait for services as set forth below and reporting it findings to CMS. Plans will offer a sub-set of HCBS services (described in subparagraph (b)(i)) to "At Risk" individuals in order to prevent a decline in health status and maintain individuals safely in their homes and communities. Based on individual assessed needs, "At Risk" individuals may be subjected to hourly or budget limitation on HCBS services that must be sufficient to meet the individual's assessed needs. This limit would be adjusted with changes in assessed need.

iv. Individuals certified as institutional LOC may be limited to a maximum of 90 days per benefit period for HCBs services furnished on a 24-hour basis.

v. The plans may have a waiting list for HCBS services for both the institutional level of care and the "At Risk" population. Waiting list policies shall be based on objective criteria and applied consistently in all geographic areas served, and are subject to the approval by the state.

vi. The will be responsible for monthly monitoring of any HCBS wait list by requiring health plans to submit the following information relevant to the waiting list:
1. The names of the members on the waiting list;
2. The date the member's name was placed on the waiting list;
3. The specific service(s) needed by the member; and
4. Progress notes on the statues of providing needed care to the members.

vii. The state shall meet with the health plans on a quarterly basis to discuss any issues associated with management of the waiting list. The purpose of these meetings will be to discuss the health plan's progress towards meeting annual thresholds and any challenges with meeting the needs of specific members on the waiting list. In addition, members who are on the waiting list may opt to change to another health plan if it appears that HCBS are available in the other plan.

viii. The state shall adopt policies that ensure authorized LTSS continue to be provided in the same amount, duration and scope while a modification, reduction or termination is on appeal. The state shall know and monitor MCO service authorization processes and intervene if those processes regularly result in participant appeals of service authorization reduction or expirations.

VII. MANAGED CARE PLAN SELECTION PROCESSES

25. **QUEST Integration.** Eligible individuals will be enrolled in a managed care plan upon initial eligibility. Eligible individual will choose among participating health plans offered to provide the full range of primary, acute, and home and community based services. Eligible individuals must be provided with information on the available health plans by the state. The state must ask each applicant to select a health plan upon determination of eligibility, the individual is automatically assigned to a plan that operates on the island of residence and will have 15 days from the date of auto assignment to select a different health plan from the list provided. The state shall send a notice of enrollment upon auto assigning the individual. The state may place enrollment limit on health plans in order to assure adequate capacity

Hawaii Medicaid 1115 Waiver Amendment Proposal to Include Tenancy Support Services May 12, 2017; July 23, 2017 JMP.cm

CMS Requirements for Amendment

When an amendment is required:

- Amendments are required when making changes related to eligibility, enrollment, benefits, cost sharing, waiting list, sources of non-federal share of funding, budget and/or allotment neutrality and other comparable program elements that are not specifically described in the STCs.
- Amendments be submitted no less than 120 days prior to planned implementation-*Per TC with CMS on 3/9/17, Hawaii will not be held to the 120 day timeline.*

Required contents of amendment request (based on current Hawaii Waiver STCs):

- A statement of the public process (in accordance with paragraph 14)
- A data analysis workbook which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. (Details below.)
- A detailed description of the amendment, including impact on beneficiaries, with supporting documentation including a conforming title XIX and/or Title XXI state plan amendment if necessary

Amendment Content

Purpose Statement

The State of Hawaii Department of Human Services is requesting an amendment to its 1115 Demonstration program, "QUEST Integration Project," as updated in the October 15, 2015 letter from CMS that reflects the Standard Terms and Conditions with technical corrections issued by CMS on that date. This amendment will allow the state to broaden its current supportive housing services as a covered service for designated beneficiaries as described in this amendment request.

Goal of this amendment:

The amendment to the current 1115 demonstration will determine whether the provision of supportive housing services that include pre-tenancy, tenancy and supported employment services, will improve health outcomes and reduce costs for the targeted subset of the Medicaid population by improving health, self-sufficiency, and providing other positive benefits as a result of these added services for the targeted population.

Hawaii has had the highest per capita homeless population in the country. This issue has raised both public health and safety concerns among Hawaii's residents statewide. Studies have shown that members of the chronically homeless population high use of hospital facilities and emergency rooms account for most of this population's disproportionately high annual health care costs. To combat this issue, both public and private stakeholders have partnered to implement "Housing First" and other permanent and supported housing

solutions in Hawaii. Access to safe, quality, affordable housing and the supports necessary to maintain this housing constitute one of the most basic and powerful social determinants of health. For beneficiaries and families trapped in a cycle of crisis and housing instability or homelessness due to extreme poverty, trauma, violence, mental illness, addiction or other chronic health conditions, lack of housing is major barrier to escaping this cycle. Hawaii wants to provide these supports to beneficiaries who are identified as chronically homeless or who have a combination of housing instability and health conditions that establish their need for supportive housing services. Currently, these beneficiaries are not provided supportive housing services under Hawaii's Medicaid program. At the last "Point in Time" count, there were 7,220 homeless individuals, of which 1,162 have serious mental illness and 1,389 have a substance use disorder (SUD). 1,800 of the individuals were chronically homeless. The majority of the chronically homeless, who by definition have a disability, suffer from either or both mental illness or substance misuse/abuse. Our data shows that the majority of the chronically homeless are enrolled in the Medicaid program. Their health costs are significantly higher than their counterparts who have stable housing. In addition, the data has shown that without access to stable housing, the chronically homeless struggle to improve their health. Thus, even if receiving treatment, it has marginal long-term health outcomes.

Based on the technical assistance that Hawaii received as a participant in the CMS Innovation Accelerator Program on Community Partnerships, Hawaii developed strong partnerships with the Hawaii Public Housing Authority, the Mental Health and Alcohol and Drug Abuse Divisions, the Governor's Homeless Coordinator's office, multiple social service and private agencies, hospitals and community health centers. Thus, although Medicaid is focused on broadening our current supportive housing benefits, it is within the larger partnership where resolving the homeless issues that currently plague our state is focused. This amendment to Hawaii's 1115 waiver is targeted on tenancy support services benefits for a targeted specific Medicaid population.

The following is a detailed description of the proposed amendment, which includes the following.

A. Statement of the public process
B. Proposed criteria for supportive housing services
C. Benefits
D. Impact on beneficiaries with supporting documentation
E. Sources of non-federal share of funding
F. Definitions

A. Statement of the Public Process

The state has complied with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994), tribal consultation requirements in section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009, and the tribal consultation requirements contained in the state's approved State plan, when any program changes to the demonstration, including

(but not limited to) changes related to eligibility, enrollment, benefits, cost sharing, waiting list, sources of non-federal share of funding, budget and/or allotment neutrality. (see attachments #1 and #2).

B. Proposed Criteria for Supportive Housing Services

All beneficiaries eighteen (18) years of age or older are eligible for supportive housing services if the individual meets he following criteria:

1. Is chronically homeless under the HUD definition or
2. Is experiencing homelessness and has one of the qualifying health conditions listed below or
3. Is living in an institution and cannot be discharged due to lack of stable housing and has one of the qualifying health conditions listed below, or
4. Is living in public housing and at risk of eviction and has one of the qualifying health conditions listed below.

Qualifying Health Conditions

- A mental health disorder which interferes with one or major life activities, or
- Has been diagnosed with substance use disorder (SUD), or
- Chronic physical or complex health needs, or
- Frequent emergency department /in-patient hospital use.

Identification of beneficiaries who meet the above criteria will be done by health plans using their encounter data, consultation with social service agencies/case management agencies' assessments and partnerships established for the Homeless Coordinated Entry program. Of note, Medicaid is also working to match the Medicaid data with the Homeless Management Information System. This will greatly enhance our health plans' ability to further offer tenancy support services for the chronically homeless population most in need.

C. Benefits

Currently, Hawaii includes supportive housing services, also known as tenancy supports, as a covered benefit for a very limited population. We have further defined and described the supportive housing benefits in Attachment F, Exhibits 1 (attachment #3) and 2 (attachment #4).

1) Attachment F, Exhibit 1 - Overview of Supportive Housing Services Delivery- This table describes the list of expanded supportive housing services and the applicable provider(s)
2) Attachment F, Exhibit 2 - Service description and definitions-This table defines each of the pre-tenancy, tenancy and other housing support services in detail.

D. Data Review: Impact of Supportive Housing on Health Care System Costs. Supporting documentation

(1) Summary table of several State's results due to housing assistance programs

Study	Methodology	Costs Saved/Avoided
Getting Home: Outcomes from Housing High-Cost Homeless Hospital Patients, Flaming & Lee (2013) Los Angeles, California	Pre-/Post-one year analysis of costs and outcomes among 163 homeless hospital patients incurring the highest 10% of public & hospital costs, per the "10th-Decile Triage Tool"	72% decline in average total health care costs from $58,962 to $16,474 (among the 36 participants who moved into supportive housing) Every $1 dollar spent to house and support a 10th decile patient is estimated to reduce public and hospital costs by$2 in the first year and $6 in subsequent years.
A Pilot Study of the Impact of Housing First-Supported Housing for Intensive Users of Medical Hospitalization & Sobering Services, D. Srebnik (2013), **American Journal of Public Health**, Feb. 103(2), 316-21 King County, Washington	One-year pre-post comparison group of homeless adults with inpatient claims of at least $10,000 or at least 60 sobering center contacts in the last year	Significant reductions in sobering center use, emergency department visits, & hospital admissions Savings of $36,579 per person per year, as compared to control group, well beyond the costs of health care & program services of $18,600
An Intervention to Improve Care & Reduce Costs for High-Risk Patients with Frequent Hospital Admissions: A Pilot Study, M. Raven & K. Doran (2011), **BioMed Central Health Services Research.** New York, New York	Pre-post one year analysis of costs and outcomes among 19 hospital patients identified as high-risk for hospital readmission by a validated predictive algorithm	37.5% reduction in hospital admissions (from 64-40), with 73.3% of participants decreasing hospital admissions Yearly Medicaid reimbursements to hospitals decreased by $16,383 per patient

Study	Methodology	Costs Saved/Avoided
"Begin at Home": A Housing First Pilot Project for Chronically Homeless Single Adults, D. Srebnik (2010). King County, Washington	Comparison between data among high-cost chronically homeless adults who received supportive housing and those who did not, one year after tenancy	74% fewer hospital admissions among supportive housing group than comparison group
Twelve-Month Client Outcomes and Service Use in a Multisite Project for Chronically Homelessness Adults, L. Richards, S. McGraw, L. Araki, et. al. (2010), **Journal of Behavioral Health Services & Research.** Multisite	Multisite evaluations of HHS, HUD, VA collaboration to house 734 chronically homeless individuals in supportive housing	79% reduction in mental health services costs 50% reduction in total quarterly health care costs of over $14,000 per year
Where We Sleep: Costs When Homeless & Housed in Los Angeles, Flaming & Burns (2009) Los Angeles County	Review of Los Angeles County public agency costs among 9,186 homeless General Relief recipients versus 1,007 residents who exited homelessness to PSH	Homeless GR recipients incurred County costs of $2,897 *per month*, versus $605 of monthly County costs among PSH residents 66% of costs were health care costs
Effect of Housing & Case Management on Emergency Room Visits and Hospitalizations Among Chronically Ill Homeless Adults Sandowski & Kee (2009), **Journal of American Medical Association** Chicago, Illinois	Randomized control-group study of 405 chronically ill, chronically homeless adults receiving supportive housing versus usual care	29% fewer hospital days and 24% fewer emergency department visits within 12 months among participants than control group 46% fewer hospital days within 18 months among participants

Study	Methodology	Costs Saved/Avoided
Health Care & Public Service Use & Costs Before & After Provision of Housing for Chronically Homeless Persons with Severe Alcohol Problems, Larimer & Malone (2009), **Journal of American Medical Association** Seattle, Washington	Randomized control-group study of chronically homeless alcoholics; 75 participants received intensive case management, using harm reduction, in housing, control group received usual care	$2,449 less in Medicaid costs per person, *per month* than control group participants after 6 months Costs avoided over and above program costs
Rhode Island's Housing First Program Evaluation, E. Hirsh & I. Glasser (2008) Rhode Island	Pre-/post evaluation of 50 chronically homeless people receiving housing and services	Health care savings averaged $7,946 per participant beyond the costs of housing and services
Frequent User of Health Services Initiative, Final Evaluation, Linkins & Brya (2008) 6 sites California-wide	Pre-/2-Year-Post-Placement evaluation of participants in program targeting high emergency room users for intensive case management	$3,841 reduction in Medi-Cal hospital costs, per beneficiary after one year $7,519 reduction in Medi-Cal hospital costs, per beneficiary per year after two years Costs avoided over and above the program costs
SUNY Research Foundation's first evaluation reports of the Medicaid Redesign Team (MRT) Supportive Housing initiative The MRT has created numerous supportive housing programs to provide vulnerable high-cost Medicaid members with rental subsidies, new capital construction and pilot projects to		Early findings demonstrate that investments in social determinants, such as housing, can have a profound impact on health care costs and utilization, including: • 40% reduction in inpatient days • 26% reduction in emergency department visits

test new models of care. Since 2012, over 11,000 high acuity Medicaid members have been served.		• 15% reduction in overall Medicaid health expenditures • On an annualized basis, the 2,071 individuals studied saw their Medicaid expenses fall by 15%, from $85,154,898 to $72,459,687. For enrollees with pre-period expenditures in the top 10% of their program, average Medicaid expenses fell by $22,814 – $52,469 per person.
Hawai'i Pathways Project (HPP) Progress Report August 2014–September 2015 HPP adopts the Pathways Housing First Model, which provides housing first and then combined with treatment services for people with psychiatric disabilities and addiction disorders. Adopted the Pathways Housing First (PHF) evidence-based program to address the behavioral and mental health needs of chronically homeless individuals on O'ahu, with a long-range goal of making an impact on ending chronic homelessness and enhancing the capacity of the homeless service system in the State of Hawai'i. HPP aims to provide: • Sustainable, permanent housing to individuals who meet the required disability conditions;	Pre/6 month post enrollment into program evaluation of housing status, ER use, drug/acohol abuse and other social determinants of health were compared. This progress report represents data on the program and selected client outcomes based on the first 14 months of implementation (August 2014 to September 2015). • All clients were chronically homeless and half experienced at least six years of continuous homelessness prior to entering HPP. • All clients were diagnosed with one of the following criteria: co-occurring substance use and mental disorders (66%); substance use only (34%); or severe mental illness only (1%). • The majority of clients were men, lifetime residents of Hawai'i, most	The overall findings indicate: • At the six-month follow-up, HPP clients were more likely to report having social support for recovery compared to at the time of program entry. • They were less likely to have ER visits, criminal justice system involvement, and alcohol and drug use; and • Were less likely to be bothered by psychological or emotional problems. • As of September 30, 2015, 38 clients (51%) were housed. All but one (37) remained in permanent rental apartments, representing a 97% retention rate. • **A preliminary analysis shows that the net savings from reduced healthcare utilization among the housed HPP clients is estimated at $2,370 per month.**

• Mainstream entitlements such as Medicaid to clients; • Community-based evidence-based treatment for substance use and psychiatric disorders that is client-driven and recovery-oriented.	self-identified as Hawaiian, with an average age of 50. • 75 clients were admitted, reaching 79% of the targeted admission number for Years 1 and 2 of the grant. • 31% of clients received some form of ID or benefit during the reporting period. • Assisted 45% of clients with applying for some form of ID or benefit (e.g., SNAP, Medicaid). • 52% of services provided were "case management"; 26% were "treatment services"; 17% were "peer-to-peer services"; 4% were "education services"; and 1% was "medical services."	
Hawaii Health Continuum of Care (Partners in Care joined Bridging the Gap) for a statewide release of the 2017 Point In Time Report. *C. Peraro Consulting, LLC, 2017 Statewide Point-In-Time (PIT) Count, May 2017*	Surveyed homeless individuals through extensive outreach efforts and compared data from point in time (PIT) 2016 to PIT 2017. The unsheltered survey is based on HUD-defined criteria and provider feedback. All surveys were entered into the PIT module of the HMIS, cleaned, unduplicated, and analyzed to obtain the data included in this report.	• 9% overall statewide decrease in the numbers of homeless individuals from 7,921 persons in 2016 to 7,220 persons in 2017. • 8% decrease in the total number of sheltered and unsheltered homeless veterans statewide • 8% decrease in the total number of chronic homeless individuals; • 19% decrease in the total number of homeless families compared to 2016.

(2) The State will use the following criteria to evaluation the effectiveness of the amendment to broaden the supportive housing services to the demonstration waiver:

- Comparison of baseline and/or control totals for members who will be receiving supportive housing services, as well as for members who are NOT receiving supportive housing services.
- Comparisons of pre and post receipt of the services.
- Comparative metrics to be used include: total medical/behavioral health costs per member per month (PMPM); number of annual emergency department (ED) visits; number of annual in-patient (IP) days, and housing status.
- Process and improvement outcome measures and specifications: will be timed to receipt of outreach tenancy services to housing; number of days transitional

Data sources and collection frequency:

- Encounter, member, and housing status data will be gathered from Hawaii Prepaid Medical Management Information System (HPMMIS), with additional housing data coming from the Managed Care Organizations (MCO) and the HMIS system, if feasible.
- The reports and comparisons will be run twice per year.

E. Sources of non-federal share of funding (and cost-neutrality):

Cost savings from reduced emergency department services and reduced hospital utilization by beneficiaries receiving supportive housing services, shall be used to offset the increased cost of implementing the supportive housing services. Initially, DHS funds have been designated to support implementation of this amendment. Projected overall savings over a five (5) year period are estimated to be $25,071,476 (see Attachment 5) based on the assumptions listed below. Thus, no additional federal/state dollars are anticipated over the life of the program.

- The attrition rate assumption is based on the historical attrition rate for the expansion population. We used this with the assumption that most were adults and their Medicaid eligibility patterns would resemble this population.
- An assumed 5% annual lapse rate back into homelessness based on the understanding that supportive housing services programs have had a high success rate of individuals remaining in a stable living situation. We have assumed a small number of members that are placed into permanent housing will eventually become chronically homeless again.
- Initial enrollment is based on estimates provided by Med-QUEST. These enrollment numbers are reasonable given the total homeless population estimate in Hawaii.
- The assumption that the most expensive members would be targeted first. The initial PMPM costs are based on the historical costs of homeless members from April 2015 to March 2016.

- As beneficiaries with lower acuity are targeted, we have assumed a lower savings. The savings rates are based on the range of results seen in other States where targeted chronically homeless members were within the top 10% of costs.
- After placement into supportive housing, we assumed members would still receive some supportive housing services, but they would not be as numerous. Therefore, we have projected an average of 0.5 hours a month at a rate of $100/hour which is $50 PMPM.
- In calculated initial costs, the assumption that placing a member in supportive housing will not be immediate and would take an average of six months for initial supportive housing placement.
- Assumptions represent the best estimates at this time. If additional research provides more refined data, we will work with our actuaries for updated results to these projections.

Of note, some of the supportive housing services that are not Medicaid eligible services will be paid for using other State funded homeless initiative dollars. The established collaboration and partnerships with these other State, federal and private entities will ensure comprehensive necessary services for the targeted population while not-duplicating services.

F. Definitions

- Chronic homelessness (HUD definition)

  (1) A "homeless individual with a disability," as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), who:

  (i) Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and

  (ii) Has been homeless and living as described in paragraph (1)(i) of this definition continuously for at least 12 months or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as described in paragraph (1)(i). Stays in institutional care facilities for fewer than 90 days will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility;

  (2) An individual who has been residing in an institutional care facility, including a jail, substance abuse or mental health treatment facility, hospital, or other similar facility, for fewer than 90 days and met all of the criteria in paragraph (1) of this definition, before entering that facility; or

  (3) A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless.

PROPOSED STC AMENDMENTS: (additions are underlined in bold)

STC 24. QUEST Integration Benefits. Benefits provided under authority of this demonstration are delivered through mandatory managed care (except as specified in subparagraph (g)), and are as follows, for all populations under the demonstration (except as otherwise provided in this paragraph):
***

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

***

v. Supportive Housing Services: Shall be provided to qualified beneficiaries who meet the criteria for and are in need of supportive housing services in order to obtain or remain in permanent housing. Services shall be approved based on referrals.

***

j) **Access to Supportive Housing Services. - To coordinate provision of supportive housing-related activities and services as appropriate with the goal of promoting community integration, optimal coordination of resources, and self-sufficiency for beneficiaries experiencing chronic homelessness who also have a disability, mental health condition, substance abuse disorder, or complex health needs. This will include outreach and engagement services, supported employment services, and other services identified as necessary to meet supportive housing goals for the beneficiary. The contracted MCO plans shall be responsible for ensuring eligible beneficiaries are provided the supportive housing services needed to secure and maintain permanent housing. Medicaid beneficiaries who meet the eligibility criteria described below shall be eligible for pre-tenancy and tenancy supportive housing services.**

All beneficiaries eighteen (18) years of age or older who is:
1.Chronically homeless under the HUD definition or
2.Experiencing homelessness and has one of the qualifying health conditions listed below or
3.Living in an institution and cannot be discharged due to lack of stable housing and has one of the qualifying health conditions listed below, or
4.Living in public housing and at risk of eviction and has one of the qualifying health conditions listed below.

Qualifying Health Conditions

- **A mental health disorder which interferes with one or major life activities, or**

- **<u>Has been diagnosed with substance use disorder (SUD), or</u>**
- **<u>Chronic physical or complex health needs, or</u>**
- **<u>Frequent emergency department / in-patient hospital use.</u>**

VII. MANAGED CARE PLAN BENEFICIARY ELIGIBILITY DETERMINATION PROCESS FOR SUPPORTIVE HOUSING SERVICES (additions are underlined in bold)

***

28. Service Coordination Model. After a beneficiary selects a health plan and completes the function described in paragraph 27, the health plan will assign a licensed or qualified professional as the beneficiaries' service coordinator, case manager and, if appropriate, a housing specialist.. .

a) Service Coordinator Responsibilities.

i. Assuring that the health plan promptly conducts a face-to-face health and functionality assessment (HFA) for each individual who is identified as meeting the eligibility criteria described above Members who are identified as having special health needs will receive a face-to-face HFA within 15 days of the documentation of special health needs.;

ii. Referring any member appearing to meet a nursing facility level of care to the state's Contractor for a functional eligibility review;

iii. Providing options counseling regarding institutional placement and HCBS alternatives;

iv. Coordinating services with other providers such as physician specialists, Medicare fee-for-service and/or Medicare Advantage health plans and their providers, mental health providers and DD/ID case managers, human and social service case managers **<u>and supportive housing services providers and specialists;</u>**

v. Facilitating and arranging access to services;

vi. Seeking to resolve any concerns about care delivery or providers;

vii. Leading a team of decision-makers to develop a care plan for those members meeting functional eligibility. The care planning team may include the primary care provider (who may be a specialist); the beneficiary, family members, and significant others (when appropriate); legal guardians, an Ombudsman if so requested by the beneficiary; and other medical care providers relevant to the beneficiary needs; and

viii. For those members meeting functional eligibility, leading the care planning team in the development of a case-specific, person-centered, cost-effective plan of care in the community, using industry best practices and guidelines established in subparagraph (b) below.

***

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
MED-QUEST DIVISION

NOTICE FOR A PUBLIC NOTICE

The State of Hawaii, Department of Human Services (DHS) (the State), hereby notifies the public that it is providing official notification concerning a proposal to amend the QUEST Expanded Demonstration project. The amendment will be filed with the federal Centers for Medicare & Medicaid Services (CMS), as an amendment to Hawaii's section 1115 demonstration (hereinafter "demonstration"), entitled, "QUEST Integration" (Project Number 11-W-00001/9) under the authority of section 1115(a) of the Social Security Act.

PURPOSE

The purpose of this posting is to provide public notice and elicit public input regarding proposed amendments to its current demonstration. These amendments will allow the State to provide supportive housing services under the Medicaid program to individuals who meet the definition of chronically homeless and who also have a mental behavioral or physical illness or a substance abuse diagnosis.. Supportive housing services include Pre-Tenancy and Tenancy support services which include but are not limited to:

Pre-Tenancy Support

- Screening and Assessments
- Develop housing support plan
- Assist with Housing search
- Application preparation and submission
- Moving assistance

Tenancy Support

- Individual housing and tenancy sustaining services
- Education and training, teach tenant responsibilities
- Teach dispute resolution with landlords and neighbors
- Service care coordination
- Job skills training and employment activities

PUBLIC COMMENT SUBMISSION PROCESS

The State has established and uses the public input process for any changes in services or operation of the waiver. Therefore, the MQD hereby notifies the public that a forum will be held to afford the public with an opportunity to provide meaningful comments about these amendments as described in this notification. ***Note:* This forum will be held in conjunction with the post award public forum.**

Date: **June 19, 2017**
Time: **8:30 am to 11:30 am**
Location: **Video Teleconference Centers (VTC)**

HILO
Hilo State Office Building
75 Aupuni Street, Basement
Hilo, Hawaii 96720

KAUAI
Lihue State Office Building
3060 Eiwa Street, Basement
Lihue, Hawaii 96766

MAUI
Wailuku State Office Building,
54 South High Street, Third Floor
Wailuku, Hawaii 96793

OAHU
Kalanimoku Building
1151 Punchbowl Street, Room B10
Honolulu, Hawaii 96813

OAHU
Kakuhihewa Building
601 Kamokila Boulevard, Room 167B
Kapolei, Hawaii 96707

Interested parties are invited to join the public forum and may provide their comments to these amendments. Space is limited for this public forum. To RSVP your attendance, please call 808-692-8132.

For all interested parties and the islands of Molokai and Lanai who are unable to travel to one of the sites above, please submit your written comments to the address provided below.

In lieu of joining the public forum in person or by video-conference, written comments may also be provided and must be received by the State from the date of publication of this notice through ***June 19, 2017*** to:

Department of Human Services
Med-QUEST Division
Attention: Policy and Program Development Office
P.O Box 700190
Kapolei, Hawaii 96709-0190
Or
quest_integration@dhs.hawaii.gov

VIEWING OF AMENDMENT

If you are interested in viewing the amendment, please call 808-692-8132 to request a copy.

Special accommodations (i.e., interpreter, large print or taped materials) will be arranged if requested no later than seven (7) working days before the comment period ends. Neighbor island residents requesting special accommodations should contact the appropriate Med-QUEST Division office on their respective neighbor island listed above.

DEPARTMENT OF HUMAN SERVICES, MED-QUEST DIVISION
JUDY MOHR PETERSON, PhD
MED-QUEST DIVISION ADMINISTRATOR

DAVID Y. IGE
GOVERNOR

PANKAJ BHANOT
DIRECTOR

BRIDGET HOLTHUS
DEPUTY DIRECTOR

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
Med-QUEST Division
Policy and Program Development Office
P. O. Box 700190
Kapolei, Hawaii 96709-0190

May 19, 2017

Ms. Joelene K. Lono
Executive Director
Ke Ola Mamo
Native Hawaiian
Health Care System-Oahu
1505 Dillingham Boulevard, Room 205
Honolulu, Hawaii 96817

Dear Ms. Lono:

RE: AMENDMENT TO HAWAII MEDICAID STATE PLAN

Pursuant to the requirement in Section 1902(a)(73) of the Social Security Act, a tribal consultation is being solicited by the Department of Human Services, Med-QUEST Division for the proposed amendments to Hawaii's section 1115 demonstration, entitled, "QUEST Integration" (Project Number 11-W-00001/9) under the authority of section 1115(a) of the Social Security Act.

This amendment will allow the State to provide supportive housing services under the Medicaid program for qualified beneficiaries who meet the definition of being chronically homeless and who also have a behavioral or physical illness or a substance abuse diagnosis. Supportive housing services include Pre-Tenancy and Tenancy support services which provide but are not limited to:

Pre-Tenancy Support

- Screening and Assessments
- Develop housing support plan

Tenancy Support

- Individual housing and tenancy sustaining services
- Education and training, teach tenant responsibilities

- Assist with Housing search
- Application preparation and submission
- Moving assistance
- Teach dispute resolution with landlords and neighbors
- Service care coordination
- Job skills training and employment activities

Please provide your written comments by June 19, 2017 to the:

Department of Human Services
Med-QUEST Division
P. O. Box 700190
Kapolei, Hawaii 96709-0190
Attention: Policy and Program Development Office

Should you have any questions or desire a meeting, please feel free to call Ms. Aileen Joy C. Befitel at 692-8078 or email her at abefitel@medicaid.dhs.state.hi.us.

Thank you for your efforts, support, and advocacy for the American Indian and Alaska Native communities and your continuing support of our Medicaid programs.

Sincerely,

for Judy Mohr Peterson, PhD
Med-QUEST Division Administrator

ATTACHMENT F
OVERVIEW OF HOUSING SERVICES
EXHIBIT 1

Eligibility Criteria for Supportive Housing Services	1. Chronically homeless (HUD definition); or 2. At risk of chronic homelessness; living in supportive or public housing and at risk of eviction; or at risk of institutional care or living in an institution and cannot be discharged due to lack of housing AND Have at least one of the HEALTH CONDITONS below			
	Adults with SMI/SPMI	Adults with mental health conditions non CCS	Adults with SUD	Adults with complex health needs, high ED/inpatient hospital use, disability and/or, chronic/multiple chronic illnesses
Pre- Tenancy Services				
Services	**Community Care Services (CCS)**	**Managed Care Plans (HP)**	**Alcohol and Drug Abuse Division (ADAD)/Managed Care Plans(HP)**	**Managed Care Plans (HP)**
Identify eligible individuals	CCS	HP	ADAD/HP	HP
Screening/Assessments	CCS	HP	ADAD/HP	HP
Develop housing support plan	CCS	HP	ADAD/HP	HP
Housing Search	CCS	HP	ADAD/HP	HP
Applications prep and submission	CCS	HP	ADAD/HP	HP
Identify resources/costs for start-up needs	CCS	HP	ADAD/HP	HP
Identify equipment, Technology, and other modifications needed	CCS	HP	ADAD/HP	HP
Ensure housing is safe	CCS	HP	ADAD/HP	HP
Moving assistance	CCS	HP	ADAD/HP	HP
Individualized housing crisis plan	CCS	HP	ADAD/HP	HP
Skill and Acquisition development	CCS	HP	ADAD/HP	HP
Independent living skills/ Financial literacy	CCS	HP	ADAD/HP	HP

ATTACHMENT F
OVERVIEW OF HOUSING SERVICES
EXHIBIT 1

Tenancy Services				
Services	**Community Care Services (CCS)**	**Managed Care Plans (HP)**	**Alcohol and Drug Abuse Division(ADAD)/ Managed Care Plans (HP)**	**Managed Care Plans (HP)**
Individual Housing and Tenancy Sustaining Services	CCS	HP	ADAD/HP	HP
Early identification/ intervention for negative behaviors	CCS	HP	ADAD/HP	HP
Education/Training roles and responsibilities of tenant/landlord	CCS	HP	ADAD/HP	HP
Coach on development/ maintenance of relationships between landlords/property managers	CCS	HP	ADAD/HP	HP
Dispute resolution with landlords/neighbors	CCS	HP	ADAD/HP	HP
Advocate & link with advocacy groups to help prevent eviction	CCS	HP	ADAD/HP	HP
Housing recertification process	CCS	HP	ADAD/HP	HP
Update/maintain housing support and crisis plans	CCS	HP	ADAD/HP	HP
Development of daily living skills and maintaining a residence skills to sustain residency	CCS	HP	ADAD/HP	HP
Service care coordination	CCS	HP	ADAD/HP	HP
Housing crisis management	CCS	HP	ADAD/HP	HP
Training/education Financial literacy Relationship building and maintenance.	CCS	HP	ADAD/HP	HP

ATTACHMENT F
OVERVIEW OF HOUSING SERVICES
EXHIBIT 1

Other Housing and Tenancy Support Services				
Services	**Community Care Services (CCS)**	**Managed Care Plans (HP)**	**Alcohol and Drug Abuse Division(ADAD)/ Managed Care Plans (HP)**	**Managed Care Plans (HP)**
Job skills training Employment activities	CCS	HP	ADAD/HP	HP
Peer Supports	CCS	HP	ADAD/HP	HP
Non-medical transportation	CCS	HP	ADAD/HP	HP
Support Groups	CCS	HP	ADAD/HP	HP
Caregiver/family support	CCS	HP	ADAD/HP	HP
Outreach and In-reach Services	CCS	HP	ADAD/HP	HP
Health Management	CCS	HP	ADAD/HP	HP
Counseling and Therapies	CCS	HP	ADAD/HP	HP
Service Assessments	CCS	HP	ADAD/HP	HP
Service Plan Development	CCS	HP	ADAD/HP	HP
Independent living skills/ Financial literacy	CCS	HP	ADAD/HP	HP
Equipment, Technology and other modifications	CCS	HP	ADAD/HP	HP
Home Management	CCS	HP	ADAD/HP	HP
Other Supplemental Services as needed	CCS	HP	ADAD/HP	HP

ATTACHMENT F
HOUSING SERVICES AND DEFINITIONS
EXHIBIT 2

Pre- Tenancy Services	Service Definition
Identify Eligible Individuals	Through a series of questions, determine whether the person meets the eligibility criteria for housing support services (See Exhibit 1). Conducting a tenant screening and housing assessment that identifies the participant's preferences and barriers related to successful tenancy.
Screening/Assessments	Establish a rapport through a "talk-story" or "person centered" model addressing the individual's needs, strengths, motivations, barriers and resources. Through the process identify functioning of individual and entire family support system and financial support. Other key areas include the individual's history (rental, credit, background clearance, and substance usage) in preparation for the meeting with the landlord. Through the person centered planning, inquire about where wants to live, with whom, income received to determine what is affordable for a rental, and special features needed for a rental. Inquire whether the person has the required documents housing agencies.
Develop Housing Support Plan	Developing an individualized housing support plan based upon the housing assessment that: Addresses identified barriers; Includes short and long-term measurable goals; Identifies the supportive housing services the individual needs; Establishes the participant's approach to meeting the goal; and Identifies when other providers or services, both reimbursed and not reimbursed by Medicaid, may be required. Develop a housing support plan that is mutually developed between the individual, housing specialist, and other identified partners based upon information gathered during the assessment phase. Housing support plans are individualized to identify services that support the individual self-sufficiency goals and shall be based on the individual's strengths, needs, and abilities. Information shall be provided about the available programs, services and resources to make informed choices about plan activities. The Housing Support Plan is updated and evaluated based upon the individual's need using information from on-going assessments by the case manager. Contact with the individual are frequent (weekly initially, monthly) based upon the needs of the individual and the support plan. The support plan reflects individual's current interests/abilities, progress, and service needs to meet short and long term goals. Factors that impact the individual's ability for employment, job readiness activities, and employment related services are addressed, and provided as appropriate. Work in tandem with individual in exploring services to support the individual in obtaining a rental (SNAP, security deposit, monthly rent, etc.)

ATTACHMENT F
HOUSING SERVICES AND DEFINITIONS
EXHIBIT 2

Housing Search	Assisting with the housing application and search process. Exploration of an affordable rental is based upon the individual's maximum allowable budget for rent and utilities that the individual has identified in their plan. Barriers: Many senior properties for individuals age 55 or 62 and above require an income of twice the rent to financially qualify for the rental. Multi-family properties may require 2.5 to 3 times the rent to financially qualify for the rental. Private landlords may require an application fee to cover the cost of a credit history or criminal history clearance. Rentals can be explored through the newspaper, Midweek, websites (craigslist, trulia.com, apartments.com, rentals.com, etc.).
Housing &/or Subsidized Rental Applications Prep and Submission	Based upon the information gathered in the assessment phase, and their individual budget, address whether the individual would be able to meet the financial criteria for rentals. If the person would not qualify for fair market rentals, consider affordable rentals with rental subsidy or rental assistance including Public Housing or Section 8 or other Federal or State housing agencies. For rent subsidized housing (public housing or housing choice vouchers-Section 8), the individual contributes 30% of the household income towards the rent, while HUD (federal Housing and Urban Development) pays for the remaining cost of the rental. Barriers: Rent subsidy is a valued commodity with a long wait list for the limited number of slots. In preparing the individual in applying for rent subsidized program, the individual needs to gather all the required documents that the housing agency requests. Work in concert with the individual in completing applications for the various housing properties. Make copies of all applications to submit and keep track of applications to maintain keep in record.
Identify Resources for Startup-Costs	Identify resources to cover/pay for expenses such as security deposit, moving costs, set-up fees for utilities or service access, including telephone, electricity, heating and water furnishings, basic household items/supplies, essential household furnishings including furniture, pots & pans, bed/bath linens, window coverings, food/cleaning supplies adaptive aids, pest eradication, one time heavy cleaning, environmental modifications, and other one-time expenses.
Equipment, Technology, and Other Modifications	Identify and ensure essential medical equipment and technology is delivered to the home prior to move. Environmental modifications should be completed prior to the move.
Ensure Housing is Safe	Walk through with the landlord to check the following: No cracks, holes, or bulges in walls and ceiling. Door and windows are able to lock and unlock. Windows provides fresh ventilation. No cracks in panes. Sliding glass doors move freely. Drains work.

ATTACHMENT F
HOUSING SERVICES AND DEFINITIONS
EXHIBIT 2

	Toilets flush. Stove, microwave, refrigerator works. Garbage disposal works well. Sinks have hot and cold running water. Refrigerator is adequate size for your family. Size of the bathroom provides privacy.
Moving Assistance	Moving assistance services are individually designed services intended to transport an individual's possessions and furnishings if needed. Moving assistance may also be utilized when the participant is moving to a location where more natural supports will be available, thus allows the participant to remain in the community in a supportive environment.
Individualized Housing Crisis Plan	Educate, inform and provide resources to help an individual access services as necessary. Identify patterns, changes in behaviors and interventions to prevent potential stress areas. (e.g. more stressed at the end of the month when funds are low, difficulty interacting with tenants in common areas, keeping unit clean, paying rent on time, neglecting personal hygiene, etc.)
Tenancy Services	**Description**
Individual Housing and Tenancy Sustaining Services	Financial guidance (i.e. paying rent and utilities in full and on time). Prevent turn off notices. Create budget and keeps spending within the budget. Keeps the rental clean and clear of clutter. Knows who to call in an emergency. Engaging in friendly neighbor relationships. Keep inside and outside apartment clutter free. Be responsible for tenants and guests in reducing noise level.
Early Identification/Intervention for Negative Behaviors	Changes in behaviors. Interacting with other tenants. Monitor upkeep inside or outside the rental. Neglecting personal hygiene. Remaining in the home for a prolonged period of time. Observe changes in habits or routines. Identifying what interventions worked or needs changes.
Education/Training Roles and Responsibilities of Tenant/Landlord	Landlord/tenant rights and responsibilities. Financial literacy. Adherence to house rules.
Coach on Development/ Maintenance of Relationships Between Landlords/Property Managers	Educate and provide resources to help an individual communicate and interact with landlords/property managers. Identify patterns, changes in behaviors and interventions to prevent potential stress in this area. (e.g. What to do if there is a problem in the unit, how to request repairs, unable to pay rent on time, etc.)
Dispute Resolution with Landlords/Neighbors	Educate and provide resources to help an individual communicate and interact with landlords and neighbors.

ATTACHMENT F
HOUSING SERVICES AND DEFINITIONS
EXHIBIT 2

	Identify patterns, changes in behaviors and interventions to prevent potential stress in this area. (e.g. How to stay calm in disputes, best ways to approach the problem, etc.)
Advocate & link with Advocacy Groups to Help Prevent Eviction	Educate, inform and provide resources to help an individual obtain access to appropriate advocacy groups.
Housing Recertification Process	Assist individual in reporting changes to the housing agency on a timely basis. Assist individual to complete the annual re-certification forms to submit to the housing office. Prepare and clean the unit in preparation for the annual inspection.
Update/Maintain Housing Support and Crisis Plans	Continue to educate, inform and provide resources to help an individual access services as necessary. Identify patterns, changes in behaviors and interventions to prevent potential stress areas. Make adjustments as needed.
Development of Good Living Skills and Maintaining a Residence Skills to Sustain Residency	Educate, inform and provide resources to help an individual develop basic living skills to enable the individual to independent living on their own. (e.g. How to upkeep their living space, how to interact with neighbors, what to do if there is a problem in the unit, how to request repairs, expectations and responsibilities, etc.)
Service Care Coordination	To be provided by the case manager assigned to the individual.
Housing Crisis Management	Family or contact person is available to respond to resident manager immediately in an event of a behavioral crisis situation. In a health related crisis, contact 911.
Other Housing and Tenancy Support Services	**Description**
Job Skills Training/Employment Activities	Supported employment services to assists with obtaining and maintaining employment.
Peer Supports	Use of peer specialists to assist in daily management activities, social and emotional support, links to clinical care and community resources, ongoing support extended over time.
Non-medical transportation	Provision of transportation for situations that do not involve an immediate threat to the life or health of an individual.
Support Groups	Provision of applicable support groups as determined by the individual's case manager, physician, social worker, housing specialist, etc.
Caregiver/family support	Emotional and/or financial support provided by the individual's assigned caregiver or family members.
Outreach and In-reach Services	Development and provision of outside agency and in house support services for the individual.
Health Management	Management of health to prevent emergency room visits or hospitalizations and maintain housing. Keeps a schedule of doctor's appointments and follows up with health care appointments. Knows the names, dosages and purposes of medications. Takes medications as prescribed by doctor. Familiar in managing health condition at home and when to call the doctor

ATTACHMENT F
HOUSING SERVICES AND DEFINITIONS
EXHIBIT 2

	or go to the emergency room. Is aware of nutrition, plans and eats well balanced meals (using four basic food groups). Is familiar with storage of food items in the home. Is aware of when food supplies are low and schedule to buy more items.
Counseling and Therapies	Appropriate counseling and other therapy services as determined by the housing specialist and case manager of the individual.
Service Assessment	Continue to establish rapport with the individual addressing the individual's needs, strengths, motivations, barriers and resources. Through the process identify functioning of individual and entire family support system and financial support.
Service Plan Development	Service plan developed and created by assigned case manager or housing specialist based on the support needs of the individual.
Independent Living/Daily Living Skills/Financial Literacy	Continue to educate, inform and provide resources to help an individual develop basic living skills to enable the individual to independent living on their own. (e.g. How to upkeep their living space, how to interact with neighbors, buying groceries, what to do if there is a problem in the unit, how to request repairs, expectations and responsibilities, etc.)
Equipment, Technology and other modifications	Continue to ensure essential medical equipment and technology is delivered to the home prior to move. Environmental modification should be completed prior to the move.
Home Management	Is able to or receives assistance in the following activities: Food containers seals to preserve items and prevent critters. Wash, dry, fold and put away clothes, linens and towels. Wash dishes. Takes the trash out on trash day (to prevent critters). Store cookware in cabinets. Use cutting board to preserve counter tops. Sweep/vacuum and mop the floor or carpet. Clean stove and microwave regularly. Changes the bed linens regularly. Cleans the counter and table tops regularly. Is aware when household supplies are low to shop for more items.
Other Supplemental Services	*Need to develop*

Hawaii Medicaid
DRAFT Med-QUEST Budget Neutrality Projection
Supportive Housing Services
Projected Savings by Year of Enrollment
Version As of 7/26/2017

Overall Net Savings:	$25,071,476

Annual Medicaid Retention Rate[1]:	0.89
Program Continued Permanent Housing Rate[2]:	0.95

Members Enrolled in 2018

Year:	2018	2019	2020	2021	2022	5 Year Total
2018 Members Still Enrolled[3]:	75	63	53	45	38	
Initial Medical Costs PMPM[4]:	$7,000					
Assumed Medical Savings[5]:	50%					
Medical Cost Savings PMPM:	$3,500	$3,500	$3,500	$3,500	$3,500	
Months of Savings	6	12	12	12	12	
Total Annual Medical Cost Savings:	$1,575,000	$2,655,055	$2,237,878	$1,886,251	$1,589,873	
Intensive Housing Support[6]:	$750					
Months of Expenses[7]	6					
Maintenance Housing Support[6]:	$350	$350	$350	$350	$350	
Months of Expenses	6	12	12	12	12	
Total Annual Supportive Housing Service Costs:	$495,000	$265,505	$223,788	$188,625	$158,987	
Net Savings:	$1,080,000	$2,389,549	$2,014,090	$1,697,626	$1,430,885	$8,612,151

Members Enrolled in 2019

Year:	2018	2019	2020	2021	2022	5 Year Total
2019 Members Still Enrolled[3]:		150	126	107	90	
Initial Medical Costs PMPM[4]:		$5,500				
Assumed Medical Savings[5]:		45%				
Medical Cost Savings PMPM:		$2,475	$2,475	$2,475	$2,475	
Months of Savings		6	12	12	12	
Total Annual Medical Cost Savings:		$2,227,500	$3,755,006	$3,164,999	$2,667,697	
Intensive Housing Support[6]:		$750				
Months of Expenses[7]		6				
Maintenance Housing Support[6]:		$350	$350	$350	$350	
Months of Expenses		6	12	12	12	
Total Annual Supportive Housing Service Costs:		$990,000	$531,011	$447,576	$377,250	
Net Savings:		$1,237,500	$3,223,995	$2,717,424	$2,290,447	$9,469,366

Members Enrolled in 2020

Year:	2018	2019	2020	2021	2022	5 Year Total
2020 Members Still Enrolled[3]:			300	253	213	
Initial Medical Costs PMPM[4]:			$4,000			
Assumed Medical Savings[5]:			40%			
Medical Cost Savings PMPM:			$1,600	$1,600	$1,600	
Months of Savings			6	12	12	
Total Annual Medical Cost Savings:			$2,880,000	$4,854,958	$4,092,120	
Intensive Housing Support[6]:			$750			
Months of Expenses[7]			6			
Maintenance Housing Support[6]:			$350	$350	$350	
Months of Expenses			6	12	12	
Total Annual Supportive Housing Service Costs:			$1,980,000	$1,062,022	$895,151	
Net Savings:			$900,000	$3,792,936	$3,196,969	$7,889,904

Members Enrolled in 2021

Year:	2018	2019	2020	2021	2022	5 Year Total
2021 Members Still Enrolled[3]:				500	421	
Initial Medical Costs PMPM[4]:				$2,500		
Assumed Medical Savings[5]:				35%		
Medical Cost Savings PMPM:				$875	$875	
Months of Savings				6	12	
Total Annual Medical Cost Savings:				$2,625,000	$4,425,091	
Intensive Housing Support[6]:				$750		
Months of Expenses[7]				6		
Maintenance Housing Support[6]:				$350	$350	
Months of Expenses				6	12	
Total Annual Supportive Housing Service Costs:				$3,300,000	$1,770,037	
Net Savings:				-$675,000	$2,655,055	$1,980,055

Members Enrolled in 2022

Year:	2018	2019	2020	2021	2022	5 Year Total
2022 Members Still Enrolled[3]:					600	
Initial Medical Costs PMPM[4]:					$1,000	
Assumed Medical Savings[5]:					30%	
Medical Cost Savings PMPM:					$300	
Months of Savings					6	
Total Annual Medical Cost Savings:					$1,080,000	
Intensive Housing Support[6]:					$750	
Months of Expenses[7]					6	
Maintenance Housing Support[6]:					$350	
Months of Expenses					6	
Total Annual Supportive Housing Service Costs:					$3,960,000	
Net Savings:					-$2,880,000	-$2,880,000

(1) - The attrition rate assumption is based on the historical attrition rate for the expansion population. We used this with the assumption that most were adults and their Medicaid eligibility patterns would resemble this population.
(2) - It is our understanding that these programs have had a high success rate where the individuals remain in a stable living situation. We have assumed a small number of members that are placed into permanent housing will eventually become chronically homeless again. We have assumed a 5% annual lapse rate.
(3) - Initial enrollment is based on estimates provided by Med-QUEST. These enrollment numbers seem reasonable given the total homeless population estimate in Hawaii.
(4) - The initial PMPM costs are based on the historical costs of homeless members from April 2015 to March 2016. We have assumed that the most expensive members would be targeted first.
(5) - Savings rates are based on the range of results seen in other States that targeted chronically homeless members within the top 10% of costs. As members with lower acuity are targeted, we have assumed a lower savings.
(6) - The cost estimates for Intensive and Maintenance Supportive Housing Services were provided by Med-QUEST.
(7) - We have assumed that placing a member in permanent housing will not be immediate therefore we assumed it would take an average of six months to place them in permanent housing.