Community Integration Services Plus (CIS+) Responsibilities

(Appendix A)

Updates to this document are inserted as shaded text and voided text from the previous version is stricken.

This document describes the benefits and responsibilities associated with Housing Navigation and Medical Respite. Health Plans have primary responsibility for the implementation of these activities but may opt to delegate the activities defined below to their contracted CIS+ Providers. If a Health Plan chooses to delegate the identified activities to a contracted provider, MQD expects that implementation efforts between Health Plans and CIS+ Providers are coordinated and collaborative. CIS+ services will be furnished only to the extent they are reasonable and necessary as clearly identified through an enrollee's person-centered service plan, when the enrollee is eligible for the service, and when the services cannot be obtained from other sources. The CIS+ program is voluntary for members.

Housing Navigation	
Service	**Responsibilities**
Pre-Tenancy Supports	i. Engaging members and obtaining consent from them to participate in CIS+ via multiple modalities, including via mail, text, phone, email, street-level engagement, and in-person meetings where the member lives, seeks care or other social services. ii. Connecting individuals to settings or programs where identified basic needs can be immediately met, such as access to shower, laundry, shelter, and food. iii. Working with the member to provide information necessary for and to conduct a housing needs assessment to identify the member's preferences related to housing (e.g., type, location, living alone or with someone else, identifying a roommate, accommodations needed, or other important preferences) and needs for support to maintain community integration (including what type of setting works best for the individual); and provide assistance in budgeting for housing and living expenses. iv. Providing members who may have needs for medical, peer, social, educational, legal, and other related services with information and logistical support. Activities include, but are not limited to, assisting members with connecting to services, helping members find and apply for necessary supports to meet their needs, assisting with filling out applications and submitting appropriate documentation to obtain sources of income necessary for community living and establishing credit, supporting understanding and meeting obligations of tenancy, and other referral activities. v. Developing an individualized care plan based upon the housing needs assessment. Identifying and establishing short- and long-term measurable goal(s) and establishing how goals will be achieved and how concerns will be addressed. Examples of short-term goals could include: identifying housing needs and preferences; assistance with move-in arrangements, support from service coordinator to ensure the housing unit is safe, meets the member's needs and is ready for move-in;

Housing Navigation	
Service	**Responsibilities**
	support from service coordinator in acquiring necessary documentation for housing application and move-in; assisting with housing search and completing housing applications; assistance from service coordinator during any housing interviews with landlords or property managers for emotional or behavioral support; requests for reasonable accommodations or appeals after housing application denials. vi. Participating in care plan meetings at enrollment, redetermination and/or revision plan meetings, as needed. vii. Providing supports and interventions per the person-centered plan. viii. Assisting in obtaining identification/ documentation (e.g., Social Security card, birth certificate, prior rental history) needed to apply for and receive benefits and other supports. ix. Assisting members with connecting to social services and the Coordinated Entry System homeless and housing service providers, to help with finding and applying for independent housing necessary to support the member to meet their medical care needs. x. Coordinating and linking the recipient to services and service providers including primary care and health homes; substance use treatment providers; mental health providers; medical, vision, nutritional and dental providers; vocational, education, employment and volunteer supports; hospitals and emergency rooms; probation and parole; crisis services; end of life planning; and other support groups and natural supports. xi. Conducting a needs assessment identifying the member's preferences related to housing (e.g., type, location, living alone or with someone else, identifying a roommate, accommodations needed, or other important preferences) and needs for support to maintain community integration (including what type of setting works best for the individual); providing assistance in budgeting for housing and living expenses; assistance in connecting the individual with social services to assist with filling out applications and submitting appropriate documentation in order to obtain sources of income necessary for community living and establishing credit, and in understanding and meeting obligations of tenancy.
Tenancy Sustaining Services	i. Service planning support and participating in care plan meetings at enrollment, redetermination, and/or revision plan meetings, as needed. This should include the development of a crisis plan or eviction prevention plan, created with the member, that includes the early identification of behaviors that could jeopardize tenancy (for example: noise violations, late rent payments, violent or threatening behaviors, guests overstaying guest policy).

Housing Navigation	
Service	**Responsibilities**
	ii. Entitlement assistance including assisting members in obtaining, maintaining, or renewing documentation, navigating and monitoring application/renewal process, and coordinating with the entitlement agency and/or Coordinated Entry providers. iii. Assistance in accessing supports to preserve the most independent living environment such as individual and family counseling, support groups, and natural supports. iv. Providing supports to assist the member in the development of independent living skills, such as skills coaching, financial counseling, and anger management. v. Providing supports to assist the member in communicating with the landlord and/or property manager regarding the participant's disability (if authorized and appropriate), detailing accommodations needed, and addressing components of emergency procedures involving the landlord and/or property manager. This may include support in creating an eviction prevention plan with the tenant, advocating for a rent repayment plan, or, if eviction proceedings begin, seeking a mutual rescission agreement with the landlord to prevent an eviction on the member's record. vi. Coordinating and linking the member to services and service providers including primary care and health homes; substance use treatment providers; mental health providers; medical, vision, nutritional and dental providers; vocational, education, employment and volunteer supports; hospitals and emergency rooms; probation and parole; crisis services; end of life planning; and other support groups and natural supports. vii. Coordinating with the member to review, update, and modify housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers. viii. Connecting the member to training and resources that will assist the individual in being a good tenant and complying with the terms of their lease, including ongoing support with activities related to household management. ix. Providing members who may have continued or newly identified needs for medical, peer, social, educational, and other related services with information and logistical support. Activities include, but are not limited to, assisting members with connecting to services, helping members find and apply for necessary supports to meet their needs, and other referral activities. x. Assisting the individual by referring the member to expert community resources to address legal issues impacting housing and thereby adversely impacting health, such as assistance with breaking a lease due to unhealthy living conditions. This service does not include legal representation or payment for legal representation.

Medical Respite Providers are reimbursed at one of two payment rates. The lower intensity MQD Level 1/2 Care Model (MQD Level 1/2) rate reflects the standards established by the National Institute for Medical Respite Care (NIMRC) Coordinated Care (Level 1) and Coordinated Clinical Care (Level 2) Models of Care. The higher intensity MQD Level 3/4 Care Model (MQD Level 3/4) rate reflects the standards established by the NIMRC Integrated Clinical Care (Level 3) and Comprehensive Clinical Care (Level 4) Models of Care and MQD's standards for delivering services to receive the MQD Level 3/4 rate.

Every Medical Respite Provider must meet the requirements for all Medical Respite Providers in the "All Medical Respite Services" row of the table below and the responsibilities for each Medical Respite service it delivers. Together, these requirements make up the MQD Level 1/2 standards. Medical Respite Providers approved for the MQD Level 3/4 rate must also meet the additional responsibilities in the last row of the table.

Medical Respite	
Service	**Responsibilities**
All Medical Respite Services *Responsibilities apply to all Medical Respite service types, in addition to other service-specific items below*	The following responsibilities apply to all Medical Respite Providers: i. **NIMRC Standards.** Meeting the eight NIMRC Standards for Medical Respite Care Programs and all related criteria. ii. **Facility Environmental and Safety Qualifications.** Responsibilities include: a. Following regulations for the storage, handling, security, and disposal of patient medications as described in HRS § 328-119; b. Maintaining written protocols for reporting adverse events using the Adverse Event Report (AER) Form described in memo QI-2513; c. Maintaining written protocols for connecting members to physical and behavioral healthcare and to other needed benefits; and d. Maintaining a written discharge protocol that gives members at least 24 hours' notice before discharge, with exceptions for administrative discharges as determined by the provider's admissions, discharge, and program safety policies. iii. **Excluded Service Settings.** Medical Respite may not be provided in: a. Congregate sleeping spaces; b. Facilities temporarily converted to shelters (e.g., gymnasiums or convention centers); c. Facilities where sleeping spaces are not available to residents 24 hours per day; d. Facilities without a private or semi-private sleeping space for each member; e. Licensed or certified facilities where treatment is the primary purpose, including Special Treatment Facilities (STFs) and Therapeutic Living Programs (TLPs); or

Medical Respite	
Service	**Responsibilities**
	f. Settings in which housing is contingent upon receiving onsite clinical treatment services. iv. **Program Knowledge.** Having knowledge of the principles, methods, and procedures of housing services covered under CIS+, including Medical Respite and Housing Navigation, and complying with the CIS+ Guidance Memo (QI-2601B/CCS-2601B). **Note:** Medication for Addiction Treatment (also referred to as medication-assisted treatment, or MAT), palliative care, hospice care, rehabilitation therapy (e.g., physical therapy, occupational therapy), outpatient substance use disorder (SUD) treatment, and ongoing individual therapy are billed separately by credentialed providers and are not part of either Medical Respite rate. Residential SUD treatment and medically managed intensive inpatient detoxification are also billed separately and are delivered in residential or inpatient settings separate from Medical Respite. The Medical Respite Provider must coordinate access when members need these services.
Short-Term Pre-Procedure Housing	i. Providing short-term housing to members ~~prior to those~~ who have a planned medical procedure requiring preparatory care (e.g., colonoscopy) or who have a planned medical treatment requiring care prior to or following treatment (e.g., chemotherapy treatment). Housing requirements include: a. A private or semi-private[1] sleeping space available to the member 24 hours a day; b. Onsite showering and laundering facilities; c. Clean linens upon admission; d. Secured storage for personal belongings and medications; and e. At least three meals a day provided. ii. When applicable and appropriate, providing clinically oriented recuperative or rehabilitative services and supports. Services are only provided for a clinically appropriate period of time and may include, but are not limited to: a. Offering medication support for members who self-manage medication, or managing medication via licensed clinical staff in collaboration with the member; b. Providing at least one wellness check every 24 hours (clinical or non-clinical staff); c. Providing access to non-emergency telemedicine or nurse line; d. Providing and/or coordinating transportation to and from needed health and health-related services (e.g., pre-procedure labs, to obtain prescriptions or medical supplies, post-operative

[1] In the CIS+ Guidance Memo, semi-private is defined as rooms with beds for two (2) to four (4) individuals that afford~~s~~ the member a sleeping space with privacy.

Medical Respite	
Service	**Responsibilities**
	appointments, etc.) and social services (e.g., appointments related to Housing Navigation). When transportation needs exceed what the provider can reasonably accommodate (e.g., inter-island travel or other extensive transportation requirements), the provider should coordinate with the member's Health Plan to arrange and authorize transportation through covered non-emergency medical transportation (NEMT); and e. Reporting incidents, member concerns, and notable changes in the member's condition to the member's designated medical provider, other respite staff members working the oncoming shift, and other entities such as QI Health Plans, as appropriate. iii. When applicable and appropriate, ~~in collaboration~~ collaborating with Health Plans to coordinate activities for physical health, behavioral health, and social needs. Such activities may include, but are not limited to: a. Screening for unmet health or social needs; b. Connecting the individual to community programs, such as substance use programs, and social benefits, in collaboration with the Health Plan; c. Coordinating with relevant case management, Health Coordination, or care management entities, including the QI Health Plan, CCS Behavioral Health Plan, and/or the Housing Navigation Provider; and d. Participating in person-centered plan meetings at CIS+ redetermination and/or revision plan meetings, as needed.
Short-Term Recuperative Care	i. Providing up to 90 days of short-term residential care to support ongoing medical and psychiatric needs. Housing requirements include: a. A private or semi-private[2] sleeping space available to the member 24 hours a day; b. Onsite showering and laundering facilities; c. Clean linens upon admission; d. Secured storage for personal belongings and medications; and e. At least three meals a day provided with monitoring and support of nutrition and diet. ii. Providing clinically oriented recuperative or rehabilitative services and supports. Services may include, but are not limited to: a. Providing basic medical clinical services onsite, including monitoring vital signs, conducting

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Medical Respite	
Service	**Responsibilities**
	assessments, wound care, and other support services; b. Offering medication support for members who self-manage medication, or managing medication via licensed clinical staff in collaboration with the member; c. Ongoing monitoring of the member's condition by clinicians; d. Providing at least one wellness check every 24 hours (clinical or non-clinical staff); e. Providing access to non-emergency telemedicine or nurse line; f. Providing and/or coordinating transportation to and from needed health and health-related services (e.g., pre-procedure labs, to obtain prescriptions or medical supplies, post-operative appointments, etc.) and social services (e.g., appointments related to Housing Navigation). When transportation needs exceed what the provider can reasonably accommodate (e.g., inter-island travel or other extensive transportation requirements), the provider should coordinate with the member's Health Plan to arrange and authorize transportation through covered non-emergency medical transportation (NEMT); and g. Reporting incidents, member concerns, and notable changes in the member's condition to the member's designated medical provider, other respite staff members working the oncoming shift, and other entities such as QI Health Plans, as appropriate. iii. When applicable and appropriate, ~~supporting~~ collaborating with Health Plans to coordinate activities for physical health, behavioral health, and social needs. Such activities may include, but are not limited to: a. Screening for unmet health or social needs; b. Connecting the individual to community programs, such as substance use programs, and social benefits, in collaboration with the Health Plan; c. Coordinating with relevant case management, Health Coordination, or care management entities, including the QI Health Plan, CCS Behavioral Health Plan, and/or the Housing Navigation Provider; and d. Participating in person-centered plan meetings at CIS+ redetermination and/or revision plan meetings, as needed.
Short-Term Post-Hospitalization Housing	i. Providing up to six months of short-term housing for members ~~individuals who do not have a residence~~ to continue recovery for physical, psychiatric, or substance use conditions following discharge or exit from an institution. Housing requirements include:

Medical Respite	
Service	**Responsibilities**
	a. A private or semi-private[3] sleeping space available to the member 24 hours a day; b. Onsite showering and laundering facilities; c. Clean linens upon admission; d. Secured storage for personal belongings and medications; and e. At least three meals a day provided with monitoring and support of nutrition and diet. ii. Providing clinically oriented recuperative or rehabilitative services and supports. Services may include, but are not limited to: a. Offering medication support for members who self-manage medication, or managing medication via licensed clinical staff in collaboration with the member; b. Providing at least one wellness check every 24 hours (clinical or non-clinical staff); c. Providing access to non-emergency telemedicine or nurse line; d. Providing and/or coordinating transportation to and from needed health and health-related services (e.g., pre-procedure labs, to obtain prescriptions or medical supplies, post-operative appointments, etc.) and social services (e.g., appointments related to Housing Navigation). When transportation needs exceed what the provider can reasonably accommodate (e.g., inter-island travel or other extensive transportation requirements), the provider should coordinate with the member's Health Plan to arrange and authorize transportation through covered non-emergency medical transportation (NEMT); and e. Reporting incidents, member concerns, and notable changes in the member's condition to the member's designated medical provider, other respite staff members working the oncoming shift, and other entities such as QI Health Plans, as appropriate. iii. When applicable and appropriate, ~~in collaboration~~ collaborating with ~~the~~ Health Plans to coordinate activities for physical health, behavioral health, and social needs. Such activities may include, but are not limited to: a. Screening for unmet health or social needs; b. Connecting the individual to community programs, such as substance use programs, and social benefits, in collaboration with the Health Plan; c. Coordinating with relevant case management, Health Coordination, or care management entities, including the QI Health Plan, CCS Behavioral Health Plan, and/or the Housing Navigation Provider; and

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Medical Respite	
Service	**Responsibilities**
	d. Participating in person-centered plan meetings at CIS+ redetermination and/or revision plan meetings, as needed.
Additional responsibilities for reimbursement at the MQD Level 3/4 rate *Applies to all Medical Respite service types*	Medical Respite Providers approved for the MQD Level 3/4 rate must meet the responsibilities below, and the member's level of care determination (Part 7 of Appendix I) must indicate a clinical need for the level at which the Medical Respite Provider is requesting reimbursement. Services may be delivered by Medical Respite program staff or through a formal partnership. A formal partnership is a contract, memorandum of understanding (MOU), or other written agreement under which a community-based partner delivers services onsite or through direct access. Direct access means members receive the service without leaving Medical Respite, or program staff facilitate access by providing transportation. i. **Onsite Medical/Clinical Monitoring and Evaluation.** Providing onsite clinical care, as described here, to every member determined to need MQD Level 3/4. Responsibilities include: a. Evaluation of each member determined to need MQD Level 3/4 by a prescribing provider (e.g., physician, Nurse Practitioner [NP], Physician Assistant [PA]) at least weekly, more often when the care plan calls for it, and within 24 hours of a reported change in condition. Evaluations may occur onsite or by telehealth; b. Clinical monitoring and support for members completing intensive outpatient treatment (e.g., dialysis, chemotherapy, complex wound care), including: ○ Monitoring the member's condition and treatment progress, as directed by discharge instructions and the member's clinical care plan; ○ Transportation to and from treatment appointments; ○ Communicating changes in the member's condition to the member's designated medical provider; ○ Communicating with outside treating providers to follow up on any changes to the member's care plan; c. Routine case conferencing between internal clinical and non-clinical providers; d. Capacity to provide more intensive medical treatment onsite (e.g., complex wound care) to members who need it, or to support those members, including transportation, in getting the treatment from an outpatient provider partner; and e. Before discharge, referral and transition to a primary care provider or health home for every member determined to need MQD Level 3/4. ii. **Medication Management.** Responsibilities include:

Medical Respite	
Service	**Responsibilities**
	a. Access to long-acting injectable (LAI) antipsychotic prescribing by a psychiatrist, behavioral health NP, or PA practicing in psychiatry, onsite or through a formal partnership; b. Administration of medications, including LAI medications, onsite by qualified clinical staff, or support, including transportation, for members to receive LAI injections from an outpatient provider partner; c. Support from qualified clinical staff for members who self-administer medications, and monitoring of members receiving IV medications; and d. Administration of IV medications by qualified clinical staff or an outpatient provider partner, either onsite or at the partner's location. iii. **Behavioral Health Care.** Offering behavioral health care to every member, as described here, which may include screening, initial evaluation and short-term support, connection to ongoing community behavioral health services, referral to community substance use treatment (including recovery, harm reduction, and Medication for Addiction Treatment [also referred to as medication-assisted treatment, or MAT]), recovery-focused group education, and harm reduction education, supplies, and services. Responsibilities include: a. Capacity to offer onsite psychiatric medication management by a psychiatrist, behavioral health NP, or PA practicing in psychiatry. Telehealth satisfies this requirement only for a Medical Respite Provider located in a rural area with an approved waiver, as described in the CIS+ Guidance Memo (QI-2601B/CCS-2601B); and b. Support, including transportation, for members to access other behavioral health services, such as MAT prescribing through a formal partnership, telehealth, or referral. iv. **24-Hour Program Staffing.** Responsibilities include: a. Program staff onsite 24 hours a day, 7 days a week; and b. At least one clinical staff member (licensed practical nurse [LPN] or higher) on every shift, trained to recognize and respond to changes in condition among higher-acuity members. v. **On-Call Medical Support.** Responsibilities include: a. 24/7 access to a clinician (e.g., physician, NP, PA) who can advise program staff, reachable by call line or direct phone; and b. A written protocol for assessing and managing a member's need for emergency department care. vi. **Documentation and Notification.** Responsibilities include: a. Keeping supporting documentation on file for review by MQD and Health Plans upon request.

Medical Respite	
Service	**Responsibilities**
	Documentation includes staffing schedules, completed staff timesheets, clinical staff licenses, clinical and medication management policies, the on-call and emergency department protocol, and contracts or MOUs with formal partners, as well as clinical documentation that justifies member need for MQD Level 3/4; and b. Notifying MQD and contracted Health Plans within 30 days of any change that affects the provider's ability to meet these responsibilities. The Medical Respite Provider may bill only the MQD Level 1/2 rate for services delivered on or after the date of the change until a Health Plan confirms the provider again meets the required MQD Level 3/4 responsibilities. If the Medical Respite Provider billed the MQD Level 3/4 rate for services delivered on or after the date of the change, it must submit corrected claims at the MQD Level 1/2 rate to any affected Health Plan within thirty (30) days of its notice. Health Plans shall recover any remaining overpayment under their existing program integrity procedures.