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November 2, 2026

MEMORANDUM

MEMO NO.
QI-2601B [Update to QI-2601A]
CCS-2601B [Update to CCS-2601A]

TO: QUEST Integration (QI) Health Plans
Community Care Services (CCS) Health Plan

FROM: Meredith Nichols MN
Med-QUEST Division Administrator

SUBJECT: COMMUNITY INTEGRATION SERVICES PLUS (CIS+) IMPLEMENTATION UPDATED GUIDELINES: MEDICAL RESPITE UPDATES – NOVEMBER 2026

INTRODUCTION

This memo modifies CIS+ memo QI-2601A/CCS-2601A (Community Integration Services Plus (CIS+) Implementation Updated Guidelines: Medical Respite Updates – July 2026).

The text of CIS+ memo QI-2601A/CCS-2601A is incorporated into this revision, identified as CIS+ memo **QI-2601B/CCS-2601B**. Updated guidance is inserted as shaded text. Voided text from QI-2601A/CCS-2601A is stricken. **Unless specified in this memo, the implementation guidelines as stated in QI-2601A/CCS-2601A are unchanged.** Any reference to days in this memo reflects calendar days.

The primary edits to QI-2601A/CCS-2601A were to implement updates to the Medical Respite benefit by February 1, 2027, including:

1. Establishing two Medical Respite payment rates, a lower intensity (MQD Level 1/2) rate and a higher intensity (MQD Level 3/4) rate, that incorporate elements of the National Institute for Medical Respite Care (NIMRC) Models of Care and MQD's level of care

standards;
2. Adding responsibilities for all Medical Respite Providers, and additional responsibilities for Medical Respite Providers receiving the MQD Level 3/4 rate to Appendix A – CIS+ Responsibilities;
3. Adding a level of care determination to Appendix I – Medical Respite Authorization Form (Part 7) that documents whether a member requires the lower intensity model of care (MQD Level 1/2) or the higher intensity model of care (MQD Level 3/4);
4. Adding Part 6 to Appendix K – Medical Respite Provider Attestation Form for Medical Respite Providers requesting eligibility for the MQD Level 3/4 rate; and
5. Adding the MQD Level 3/4 rate to Table 6.

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CIS+ Program Description

1. Program Overview

The purpose of this document is to outline the requirements of the Community Integration Services Plus (CIS+) program and provide Health Plans with updated guidance on benefit parameters, eligibility, Health Plan responsibilities, forms, and other program details. The CIS+ benefits described in this document include both previously approved and implemented Community Integration Services (CIS) benefits, as well as the new Medical Respite benefits approved under Hawaii's QUEST Integration Section 1115 Demonstration, effective from January 8, 2025, through December 31, 2029. The program parameters described in this guidance align with approved Special Terms and Conditions (STCs) as established by the Centers for Medicare & Medicaid Services (CMS) in the Section 1115 Demonstration approval, as well as other federal guidance and requirements under Medicaid, such as eligibility, service planning, and reporting.

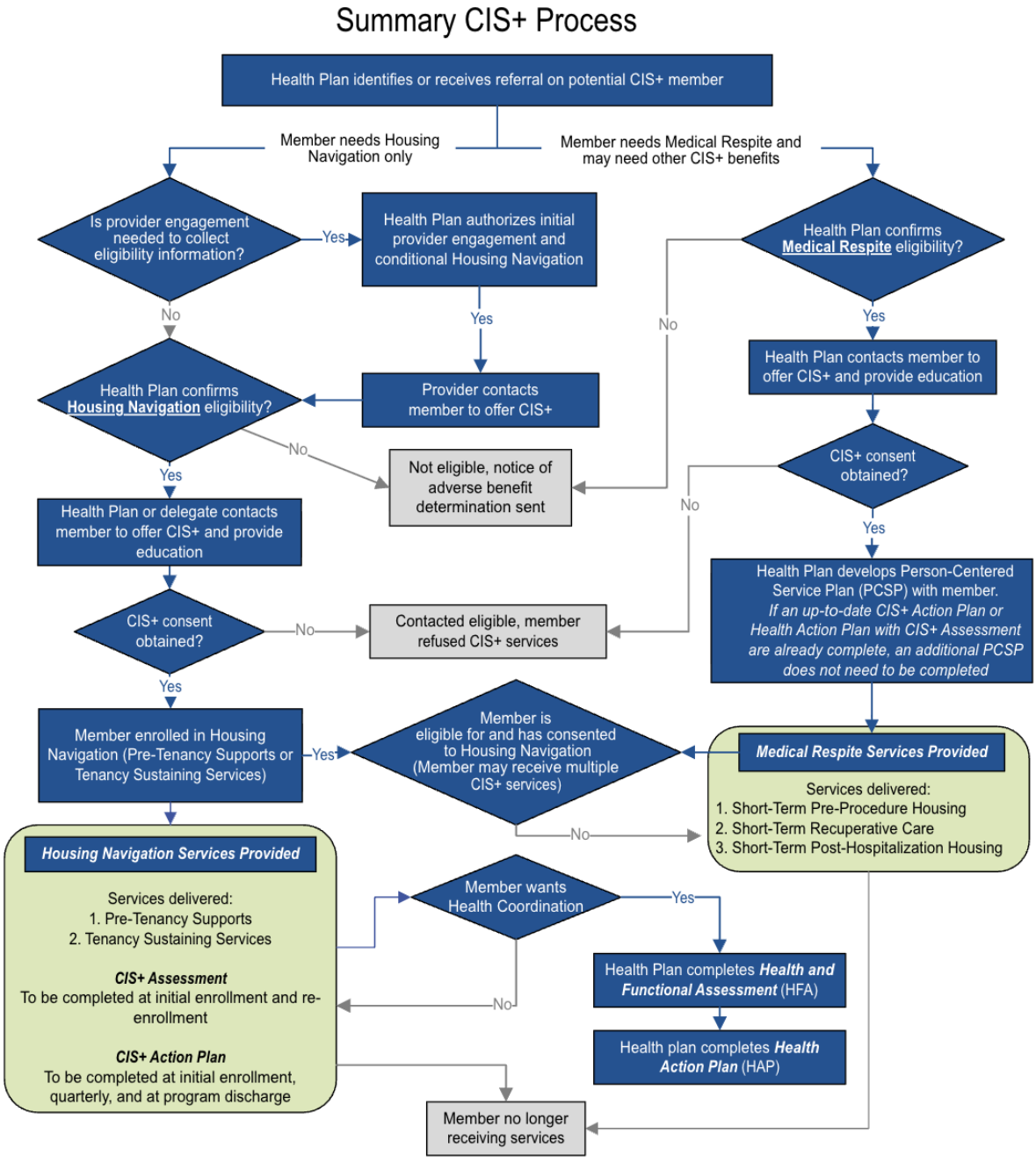
Community Integration Services Plus (CIS+) – previously named Community Integration Services (CIS) – assists eligible members with becoming fully integrated members of the community as well as achieving improved health outcomes and life satisfaction. Effective January 1, 2026, the CIS+ program includes two (2) types of housing-related benefits: Housing Navigation and Medical Respite, described below:

1. *Housing Navigation*, which includes both Pre-Tenancy Supports and Tenancy Sustaining Services.
2. *Medical Respite*, which includes Short-Term Pre-Procedure Housing, Short-Term Recuperative Care, and Short-Term Post-Hospitalization Housing.
    a. CIS+ Providers and Health Plans shall highly encourage members to receive Housing Navigation while in Medical Respite.

Med-QUEST Division (MQD) intends to add additional housing support benefits to CIS+ in a phased approach. Detailed descriptions of the responsibilities associated with each benefit are outlined in Appendix A – CIS+ Responsibilities. All CIS+ services must be provided in a way that is culturally responsive and ensures meaningful access to language services.

Figure 1 below provides a high-level summary of the CIS+ program process. For a more detailed CIS+ Process graphic that includes additional steps, billing codes, and CIS+ Status Codes, see Appendix H – CIS+ Process Flow.

Figure 1: Summary CIS+ Process



2. Housing Navigation

Housing Navigation Services

When paired with affordable housing[1], Housing Navigation services are a cost-effective way to engage members experiencing homelessness, help reduce homelessness, and increase housing stability. CIS+ seeks to engage the member in self-care and personal management by establishing a personalized housing support plan (See Appendix E – CIS+ Action Plan) that is holistic and reflective of member preferences and goals.

Health Plans may authorize services in up to three (3)-month increments, as needed, provided the individual remains eligible. There are two Housing Navigation services:

1. *Pre-Tenancy Supports* help members in identifying and securing housing and preparing to become successful tenants. Supports may include assessing housing needs and preferences, assisting with documentation and benefits, linking the individual to immediate basic needs and supportive services, coordinating the housing search and move-in process to promote stable community living, and other similar services.
2. *Tenancy Sustaining Services* support members in maintaining stable housing and independent living sustainability. Supports may include tenant/landlord education, tenant coaching on independent living, financial management, household skills, tenant assistance with community integration and inclusion to help develop natural support networks, connecting the individuals to community resources and benefits, and providing referrals to address housing-related legal or tenancy issues, as needed.

Housing Navigation Referrals

Individuals can be referred to Housing Navigation through the CIS+ Referral Form provided in Appendix B. Any member, individual, or organization can use this form to refer members for any CIS+ service. Upon referral notification, the Health Plan will independently verify if the member meets eligibility criteria. See the Eligibility Criteria section for more detail on eligibility criteria and processes.

Housing Navigation Service Settings

Pre-Tenancy Supports may be rendered on the street, on the beach, in a vehicle, in a shelter, in a residential, institutional, or licensed setting, in an emergency room, in an acute institution, in a health care provider office, or other locations of the member's choosing. Tenancy Sustaining Services are most often rendered at the member's home but may also be rendered in other community settings where Pre-Tenancy Supports are rendered. Services may also be rendered via an approved telehealth modality, if determined by the Health Plan to be appropriate and effective and agreed to by the member.

[1] U.S. Department of Housing and Urban Development (HUD), Glossary of Community Planning and Development. https://www.hud.gov/program_offices/comm_planning/library/glossary/a. Note: HUD defines affordable housing as "Housing for which the occupant is paying no more than 30 percent of his or her income for gross housing costs, including utilities."

3. Medical Respite

Medical Respite Services

Medical Respite services (also referred to as "episodic interventions" in the Section 1115 Demonstration approval) provide eligible members short-term room and board with clinical services and other supports. The benefit is designed and federally authorized to support members with short-term needs to recover from or prepare for clinical events in safe, stable, and supportive housing.

There are three distinct Medical Respite services:

1. *Short-Term Pre-Procedure Housing* offers short-term housing and clinically oriented recuperative or rehabilitative services for members who have a scheduled medical procedure that requires preparatory care, or for those undergoing planned treatment that necessitates care before or after the procedure. Pre-procedure or pre-treatment Medical Respite stays should be no longer than seven (7) days. Post-procedure or post-treatment Medical Respite stays should be no longer than 3 days. If a longer stay is needed, members should be assessed for eligibility for Short-Term Recuperative Care or Short-Term Post-Hospitalization Housing.
2. *Short-Term Recuperative Care* provides short-term housing, clinically oriented recuperative or rehabilitative services, and monitoring for members with ongoing medical or psychiatric needs in need of continuous access to medical care. A member may receive up to ninety (90) consecutive days of this care. If the member later develops a new or renewed need, they may access the benefit again, as long as they remain within the overall Medical Respite limit of six (6) months within a twelve (12)-month rolling period.
3. *Short-Term Post-Hospitalization Housing* provides short-term housing and clinically oriented recuperative or rehabilitative services to members in continued recovery from a physical, psychiatric, and/or substance use condition following discharge from an institution. This service is subject only to the aggregate Medical Respite limit; there is no separate limit specifically for post-hospitalization housing.

Medical Respite services are time-limited based on clinical and social need. Each Medical Respite benefit may be authorized for limited time periods, not to exceed a combined six months within a rolling 12-month period. The rolling 12-month period starts on the day that Medical Respite benefits begin. Health Plans are responsible for monitoring these benefit limits. If a member changes Health Plans, the former Health Plan is responsible for communicating the dates and length of Medical Respite stays as described in QI contract Section 9.3.B. MQD may update the Health Plan change and transition of care file template (QI-2419A) to include basic information on Medical Respite benefit usage.

Medical Respite Service Settings

A variety of settings may provide Medical Respite services, provided they are registered as A8 Providers and contracted with Health Plans. These settings may include, but are not limited to:

- Interim housing facilities with additional on-site support (e.g. Kauhales)
- Shelter beds with additional on-site support
- Converted homes with additional on-site support
- Publicly operated or contracted recuperative care facilities
- Supportive housing providers
- County agencies
- Public hospital systems
- Social service agencies
- Providers of services for individuals experiencing homelessness

Medical Respite CANNOT be provided in the following settings:

- Congregate sleeping spaces
- Facilities that have been temporarily converted to shelters (e.g. gymnasiums or convention centers)
- Facilities where sleeping spaces are not available to residents twenty-four (24) hours a day
- Facilities without private or semi-private sleeping space
- Licensed or certified facilities where treatment is the primary purpose, including Special Treatment Facilities (STFs) and Therapeutic Living Programs (TLPs)
- Settings in which housing is contingent upon receiving onsite clinical treatment services

Medical Respite Providers must offer private rooms or semi-private rooms, the latter defined as rooms with beds for two (2) to four (4) individuals that afford the member a sleeping space with privacy. Medical Respite must be provided within Medical Respite settings that meet the requirements described in Appendix A.

Medical Respite Clinical Appropriateness

In addition to meeting the benefit eligibility criteria described in the Eligibility Criteria section, members must have clinical and support needs that can be safely and appropriately addressed in a Medical Respite setting. This section outlines considerations for determining the clinical appropriateness of Medical Respite for members. It also aligns with MQD's commitment to promoting quality member care and preventing fraud, waste, and abuse (FWA), as further described in the Program Integrity Responsibility section of this guidance.

Medical Respite is intended to provide short-term housing and support to members who need a safe place to prepare for or recover from a physical or mental health event. The benefit is not designed and does not have the federal authority to provide intensive or specialized treatments that fall outside of the scope of Medical Respite, as defined in Attachment F of the Section 1115 Demonstration approval and Appendix A. Examples include, but are not limited to, inpatient

psychiatric care, residential substance use disorder (SUD) treatment, and long-term services and supports (LTSS).

Members receiving Medical Respite services may have co-occurring SUD, mental health conditions, functional limitations, or other complex care needs. The presence of these needs does not automatically make Medical Respite inappropriate for a member. However, **services that fall outside of the scope of Medical Respite must be delivered and billed separately by appropriately licensed, credentialed, certified, or otherwise qualified providers in accordance with federal and state law and Medicaid requirements**, even if such services are delivered concurrently at the Medical Respite facility. Examples of services that shall be billed outside of Medical Respite include, but are not limited to: Medication for Addiction Treatment (also referred to as medication-assisted treatment, or MAT), palliative care, hospice care, rehabilitation therapy (e.g., physical or occupational therapy), outpatient SUD treatment, and ongoing individual therapy. Residential SUD treatment and medically managed intensive inpatient detoxification are also billed outside of Medical Respite. These services are delivered in residential or inpatient settings separate from Medical Respite.

When a member requires services that fall outside of the scope of Medical Respite, the Medical Respite Provider shall ~~should~~ coordinate with the member's Health Plan and qualified providers to ensure the member receives appropriate care and support. Appropriate care and support may include care coordination, medication management, appointment scheduling, recovery planning, and connection to community resources.

Health Plans are responsible for ensuring that members receive care in the most appropriate setting based on the member's needs and the capabilities of the specific Medical Respite Provider. Because Medical Respite Providers may vary in staffing, licensure, clinical partnerships, and service capacity, some Medical Respite Providers may be able to support members with more complex needs than others. Accordingly, Health Plans must work closely with Medical Respite Providers to confirm that the provider can meet the member's clinical, behavioral health, functional, and support needs before authorizing placement.

Generally, Medical Respite services may be clinically appropriate for a member if the member:

1. Has full decision-making capacity or appropriate supports for decision-making;
2. Is able to live independently or needs only short-term assistance with regaining the ability to live independently as part of the recuperative process;
3. Is independent with activities of daily living (ADLs) and instrumental activities of daily living (IADLs), or needs only short-term assistance with regaining the ability to perform ADLs and IADLs as part of the recuperative process;
4. Has an acute or chronic clinical issue that is likely to resolve, improve greatly, or stabilize through a Medical Respite stay.

Medical Respite services may not be clinically appropriate if the member has one (1) or more of the following:

1. Condition(s) that require services or support beyond the Medical Respite Provider's

staffing, licensure, or operational capacity (this may vary by provider site and capacity);
2. A need for medical assistance to administer medications or treatments that the Medical Respite Provider is not licensed or staffed to provide;
3. Incontinence that cannot be self-managed or supported safely by the Medical Respite Provider; or ~~and~~
4. High-acuity physical or behavioral health needs requiring inpatient hospitalization or ~~another, higher level of~~ other institutional care.

MQD strongly supports collaborative partnerships between Medical Respite Providers, SUD treatment providers, behavioral health providers, hospitals, and other community organizations. Ultimately, the goal is to ensure members receive the right services, from the right providers, in the most appropriate setting based on their individual needs.

Medical Respite Levels of Care

Beginning February 1, 2027, MQD recognizes two Medical Respite care models. MQD's standards are based on the National Institute for Medical Respite Care (NIMRC) Models of Medical Respite Care (2025).[2] MQD standards and Medical Respite Provider responsibilities for each level are described in Appendix A.

- *MQD Level 1/2 Care Model:* MQD's Level 1/2 standards are based on the NIMRC Coordinated Care (Level 1) and Coordinated Clinical Care (Level 2) models.
  - All registered Medical Respite Providers must meet at least these standards.
- *MQD Level 3/4 Care Model:* MQD's Level 3/4 standards are based on the NIMRC Integrated Clinical Care (Level 3) and Comprehensive Clinical Care (Level 4) models.
  - Only Medical Respite Providers that meet these standards and are approved to do so may bill for the MQD Level 3/4 rate.
  - Medical Respite Providers requesting eligibility to receive reimbursement at MQD Level 3/4 must complete Part 6 of Appendix K – Medical Respite Provider Attestation Form and follow the processes outlined in Appendix K.

A member's level of care is determined in Part 7 of Appendix I – Medical Respite Authorization Form. Health Plans reimburse at the MQD Level 3/4 rate only when the Medical Respite Provider is approved for MQD Level 3/4 and the member's level of care determination indicates a clinical need for that level. When a Qualified Health Professional affiliated with the Medical Respite Provider completes a level of care determination that moves a member from MQD Level 1/2 to MQD Level 3/4, the Medical Respite Provider must attach supporting clinical documentation. A Health Plan clinical reviewer must confirm the determination before the Health Plan authorizes the MQD Level 3/4 rate.

Medical Respite Referral, Service Authorization, and Ongoing Clinical Appropriateness Verification

[2] National Health Care for the Homeless Council (NHCHC), Models of Medical Respite Care (2025). https://nhchc.org/wp-content/uploads/2025/03/Models-of-Medical-Respite-Care_2025_final.pdf

Referral: Individuals can be referred for Medical Respite services using the Medical Respite Authorization Form provided in Appendix I.

- *Completion of the Medical Respite Authorization Form:* The Medical Respite Authorization Form must be reviewed, approved, and signed by a Qualified Health Professional. The completed Medical Respite Authorization Form should be sent to the member's Health Plan.
    - *NOTE:* If the Medical Respite Authorization Form is completed, a CIS+ Referral Form is not needed. Individuals or organizations that are not Qualified Health Professionals may complete the CIS+ Referral Form to inform a Health Plan of a member's potential need for Medical Respite.
- *Qualified Health Professional:* Qualified Health Professionals include Doctors of Medicine, Doctors of Osteopathic Medicine, Nurse Practitioners, and Physician Assistants. Qualified Health Professionals may use support staff to complete the Medical Respite Authorization Form, so long as the Qualified Health Professional provides final review, approval, and signature.
- *Conflicts of Interest:* The Qualified Health Professional completing the Medical Respite Authorization Form must be free from conflicts of interest with the Medical Respite Provider. Conflicts of interest include, but are not limited to, being employed by or having a financial relationship with the Medical Respite Provider.

Service Authorization: Health Plans are responsible for service authorization.

- *Member Eligibility:* Upon receipt of a referral, Health Plans have 7 days to independently determine if the member meets eligibility criteria for Medical Respite services. For members in an institution, if the discharge date is known, the Health Plans shall attempt to conduct an eligibility screening before the member is discharged. MQD anticipates that Health Plans will use the information provided in the Medical Respite Authorization Form to determine eligibility and coordinate with Medical Respite Providers to ensure that the member's care needs can be safely and appropriately met in the proposed setting. Health Plans may request additional information from the referring Qualified Health Professional to support eligibility determinations or assess the member's care needs. When assessing a member's eligibility for Short-Term Recuperative Care, Health Plans may not deny the service solely because the member has no prior inpatient or emergency department utilization. When reviewing a request, Health Plans shall consider a range of clinical factors that may affect the member's ability to recover safely in the community, such as wound care or medication needs, functional limitations, behavioral health symptoms, cognitive status, and the lack of a safe place to recover.
- *Initial Service Authorization:* Upon determining that the member meets eligibility criteria for Medical Respite, the Health Plan shall authorize Medical Respite services for

a specified portion of time based on the member's clinical needs, expected recovery, and level of care determination as documented in the Medical Respite Authorization Form.

- *Extending Service Authorization:* If additional Medical Respite services are necessary beyond the initial authorization period, a Qualified Health Professional may request an extension. To request an extension, a Qualified Health Professional must complete and submit an updated Medical Respite Authorization Form (Parts 1–3 and Part 7) to the member's Health Plan. The Qualified Health Professional may be affiliated with the Medical Respite Provider. The Health Plan will review the request for the service authorization extension and determine whether continued Medical Respite services are appropriate for the member based on their individual clinical needs. The updated Medical Respite Authorization Form (Parts 1–3 and Part 7) must include a complete level of care determination (Part 7), including supporting clinical documentation.

- *Retroactive Service Authorization:* Medical Respite Providers may accept patients before Health Plan authorization is issued. Health Plans have 7 days to complete retroactive authorization. If the Health Plan approves the retroactive authorization, the Health Plan shall reimburse the Medical Respite Provider for services dating back to the member's date of admission. The Medical Respite Provider and the discharging institutional organization (e.g., a hospital) must establish, by mutual agreement, which entity will assume financial risk if the Health Plan ultimately denies authorization for the Medical Respite stay. Either party may assume full financial risk, or the parties may agree to share risk. MQD encourages all entities involved to work closely with Health Plans to design and agree upon an appropriate process. ~~Before a member is admitted to~~ Retroactive authorization for Medical Respite requires three items: ~~must be in place~~:

    - *Medical Respite Authorization Form:* The member's Health Plan must approve a complete Medical Respite Authorization Form submitted by a Qualified Health Professional free from conflicts of interest with the Medical Respite Provider;

    - *Consent:* The Health Plan or an organization free from conflicts of interest with the Medical Respite Provider and delegated by the Health Plan (e.g., a hospital, CIS+ Provider, etc.) must solicit and receive member consent to participate in the CIS+ program to receive Medical Respite; and

    - *Person-Centered Service Plan (PCSP):* The Health Plan or an organization free from conflicts of interest with the Medical Respite Provider and delegated by the Health Plan must complete a PCSP. While it is highly recommended that the PCSP be completed prior to admission to Medical Respite, the PCSP must be completed within 3 days of admission, or within 3 days of Health Plan authorization for members admitted before authorization is issued.

Ongoing Clinical Appropriateness Verification: In addition to obtaining service authorization from the member's Health Plan, the clinical appropriateness of Medical Respite must be

verified every 30 days for members whose authorized stay exceeds 30 days (e.g., a Medical Respite stay of 90 days).

- *Medical Respite Provider Responsibility:* The Medical Respite Provider must submit a Medical Respite Authorization Form (Parts 1–3 and Part 7) to the member's Health Plan every 30 days. Parts 1–3 and Part 7 of the form can be completed by any Qualified Health Professional, regardless of whether the professional is affiliated with the Medical Respite Provider. The Medical Respite Provider must submit Parts 1–3 and Part 7 of the Medical Respite Authorization Form no later than 30 days following the member's admission to ~~the~~ Medical Respite and every 30 days thereafter for the duration of the member's stay. Alternatively, the Medical Respite Provider can coordinate with a Qualified Health Professional not affiliated with the Medical Respite Provider to ensure that a Medical Respite Authorization Form is submitted every 30 days.

- *Health Plan Responsibility:* Upon receipt of Parts 1–3 and Part 7 of a completed Medical Respite Authorization Form, the member's Health Plan will review the form to verify whether Medical Respite remains clinically appropriate for the member. The Health Plan must make a determination of clinical appropriateness within seven (7) days of receiving the form. If the Health Plan determines that Medical Respite remains clinically appropriate, the member may continue receiving Medical Respite services through the remainder of the verified 30-day period, subject to any applicable service authorization limits. If the member's level of care determination changes, the Health Plan shall authorize the corresponding rate described in the Medical Respite Levels of Care section, beginning on the date that the form was submitted. Health Plans shall authorize the MQD Level 3/4 rate only if the Medical Respite Provider is approved for MQD Level 3/4; otherwise, the provider continues to be reimbursed at the MQD Level 1/2 rate. In the event a Qualified Health Professional requests an extension for a higher (MQD Level 3/4) level of care for a member to meet their medical and/or behavioral health needs, and the Health Plan determines the member remains at the MQD Level 1/2 level of care, the decision is considered a full denial, with appeal rights available to the member.

- If the Health Plan determines that Medical Respite is no longer clinically appropriate for the member, the Health Plan shall:
    - Notify the member and the Medical Respite Provider of the decision;
    - Issue a notice of adverse benefit determination;
    - End coverage for Medical Respite services no later than 2 weeks after communicating the determination; and
    - Coordinate, as appropriate, with the Medical Respite Provider to identify a more suitable setting for the member.

Connection between Medical Respite and Housing Navigation

Members can benefit from receiving both Medical Respite and Housing Navigation at the same time. For example, Housing Navigation can help members receiving Medical Respite to secure housing before the authorized Medical Respite period ends. Members may also request additional CIS+ services at any time if they are eligible.

All members receiving Medical Respite should be enrolled in Housing Navigation, unless they decline participation or are otherwise ineligible. Members receiving Short-Term Recuperative Care or Short-Term Post-Hospitalization Housing are automatically eligible for Housing Navigation. However, members receiving Short-Term Pre-Procedure Housing are not automatically eligible; those receiving Short-Term Pre-Procedure Housing may or may not have a complex behavioral or physical health need that would qualify them for Housing Navigation.

Health Plans and/or CIS+ Providers shall provide education on CIS+ services at key milestones:

1. *When obtaining consent:* The member will be educated on the CIS+ program, including the full range of CIS+ services potentially available to them.
2. *During the CIS+ Assessment or CIS+ Action Plan development:* During development of the CIS+ Assessment and CIS+ Action Plan, a member's need for the full range of CIS+ services should be assessed. If additional needs are identified, the Health Plan shall review and authorize additional CIS+ services as appropriate based on clinical and social needs.
3. *When a member is discharged from Medical Respite:* If the member is not discharged to permanent housing or a long-term institutional setting, the Health Plan shall re-engage the member to discuss other CIS+ benefit options, such as Housing Navigation.

Transportation within Medical Respite

Transportation is recognized as an important part of the model of care for Medical Respite; as such, costs associated with Medical Respite Provider responsibilities for transportation are included as a component in the per diem rate. Medical Respite Providers are responsible for 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 CIS+ Housing Navigation). Examples of instances where transportation may be provided or coordinated include, but are not limited to:

- Travel to and from the discharging or treating institution and ~~the~~ Medical Respite ~~facility~~;
- Preparatory, follow-up, or discharge appointments with a surgical provider or other treating provider related to the member's Medical Respite stay;
- Lab, radiology, or diagnostic services;
- Medical, behavioral health, or substance use disorder treatment appointments (e.g., travel to a methadone clinic);
- Pharmacy or medical supply pick-up; and,
- Other benefits, services, or destinations related to the provision of CIS+ Medical Respite

and Housing Navigation, as indicated in the member's PCSP.

When transportation needs exceed the Medical Respite Provider's reasonable capacity or capabilities—for example, inter-island travel, specialized medical transport—the provider must work with the Health Plan to authorize and arrange the appropriate transportation benefit. To avoid duplicate payments for transportation services, Medical Respite Providers may not separately bill Health Plans for non-emergency medical transportation (NEMT) services for transportation that is already covered under the Medical Respite per diem rate.

Table 1: Health Plan and CIS+ Provider Transportation Roles in Medical Respite

Health Plan Role	CIS+ Provider Role
• Provide for NEMT-covered transportation needs when they exceed the Medical Respite Provider's capacity or capabilities (e.g., inter-island travel, specialized transport). • Ensure no duplicate payments are made to Medical Respite Providers for transportation already covered under the Medical Respite benefit.	• Provide and/or coordinate transportation to and from needed health and health-related services and social services. Medical Respite Providers may not bill transportation services separately. • Coordinate with the Health Plan if additional transportation is required beyond the Medical Respite Provider's capacity or capabilities.

4. Eligibility Criteria

Any QUEST Integration (QI) eligible member who is homeless or is at risk of becoming homeless can be referred to the member's Health Plan for CIS+ screening to determine program eligibility. There are no restrictions on who can make the referral. The Department of Human Services (DHS) is expecting referrals to come from a variety of sources, including, but not limited to, self or family members, homeless services providers, other community-based organizations, and healthcare providers.

The CIS+ eligibility criteria are intentionally broad to reduce barriers to services. MQD will publicly maintain CIS+ eligibility criteria on the Hawaii Medicaid State Plan and Demonstration webpage (see Section 1115 Demonstration Renewal for 2024). Health Plans shall maintain these criteria on a public-facing webpage. In the future, when the public-facing criteria change, the website content shall be updated within 1 month of MQD notice.

Medicaid and CIS+ benefits are associated with individual members, not families. CIS+ benefit eligibility criteria include the following and are described in more detail below:

1. Has a social risk factor (i.e., being homeless or at risk of homelessness); and,
2. Has a clinical need (i.e., complex physical or mental health condition, and/or need for Medical Respite service). Each CIS+ service has specific clinical criteria, see Table 2: Clinical Need Definitions

Social Risk Factor Definition

Per the Section 1115 Demonstration approval, an individual who is at least 18 years of age and "homeless" or "at risk of homelessness" as defined by the Housing and Urban Development (HUD) and codified in 24 CFR 91.5, with the following modifications:

1. The timeframe for an individual or family who will imminently lose housing is extended from fourteen (14) days for individuals considered homeless under the HUD definition to twenty-one (21) days;
2. Individuals and families are considered at risk of homelessness if they have been notified that they will lose their current housing or living situation in writing or with verbal notification; and
3. Individuals and families are considered at risk of homelessness without additional income-based eligibility determinations (removes requirement that individuals or families have an annual income below 30 percent of Median Family Income).

As of October 2025, the HUD definitions of "homeless" and "at risk of homelessness," with CMS-approved modifications, are listed below.

- *At risk of homelessness.*
  (1) An individual or family who:
    (i) Does not have sufficient resources or support networks, *e.g.,* family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the "Homeless" definition; and
    (ii) Meets one of the following conditions:
      (A) Has moved because of economic reasons two or more times during the sixty (60) days immediately preceding the application for homelessness prevention assistance;
      (B) Is living in the home of another because of economic hardship;
      (C) Has been notified in writing or verbally that their right to occupy their current housing or living situation will be terminated within twenty-one (21) days after the date of application for assistance;
      (D) Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;
      (E) Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;
      (F) Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or
      (G) Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's

approved consolidated plan.

- *Homeless*
  (1) An individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning:
    (i) An individual or family with a primary night-time residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground;
    (ii) An individual or family living in a supervised, publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state, or local government programs for low-income individuals); or
    (iii) An individual who is exiting an institution where he or she resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution;
  (2) An individual or family who will imminently lose their primary nighttime residence, provided that:
    (i) The primary nighttime residence will be lost within twenty-one (21) days of the date of application for homeless assistance;
    (ii) No subsequent residence has been identified; and
    (iii) The individual or family lacks the resources or support networks, e.g., family, friends, faith-based or other social networks needed to obtain other permanent housing;
  (3) Unaccompanied youth 18 to 25 years of age, or families with children and youth, who do not otherwise qualify as homeless under this definition, but who:
    (i) Are defined as homeless under section 387 of the Runaway and Homeless Youth Act (42 U.S.C. 5732a), section 637 of the Head Start Act (42 U.S.C. 9832), section 41403 of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2), section 330(h) of the Public Health Service Act (42 U.S.C. 254b(h)), section 3 of the Food and Nutrition Act of 2008 (7 U.S.C. 2012), section 17(b) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)), or section 725 of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a);
    (ii) Have not had a lease, ownership interest, or occupancy agreement in permanent housing at any time during the sixty (60) days immediately preceding the date of application for homeless assistance;
    (iii) Have experienced persistent instability as measured by two moves or more during the sixty (60)-day period immediately preceding the date of applying for homeless assistance; and
    (iv) Can be expected to continue in such status for an extended period of time because of chronic disabilities, chronic physical health or mental health conditions, substance addiction, histories of domestic violence or childhood

abuse (including neglect), the presence of a child or youth with a disability, or two or more barriers to employment, which include the lack of a high school degree or General Education Development (GED), illiteracy, low English proficiency, a history of incarceration or detention for criminal activity, and a history of unstable employment; or

(4) Any individual or family who:
  (i) Is fleeing, or is attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the individual or a family member, including a child, that has either taken place within the individual's or family's primary nighttime residence or has made the individual or family afraid to return to their primary nighttime residence;
  (ii) Has no other residence; and
  (iii) Lacks the resources or support networks, e.g., family, friends, faith-based or other social networks, to obtain other permanent housing.

Table 2: Clinical Need Definitions

Clinical Need	Need Description	What CIS+ Services is the Member Eligible For?
Complex Behavioral Health Need	1. Mental health need, where there is a need for improvement, stabilization, or prevention of deterioration of functioning (including ability to live independently without support) resulting from the presence of a serious mental illness; **and/or** 2. Substance use need, where an assessment using American Society of Addiction Medicine (ASAM) criteria indicates that the individual meets at least ASAM level 2.1 indicating the need for intensive outpatient treatment for SUD.	• Pre-Tenancy Supports • Tenancy Sustaining Services
Complex Physical Health Need	Member assessed to have a complex physical health need, which is defined as a long continuing or indefinite physical condition requiring improvement, stabilization, or prevention of deterioration of functioning (including the ability to live independently without support).	• Pre-Tenancy Supports • Tenancy Sustaining Services
Short-Term Pre-Procedure Housing Need	Have a planned medical procedure requiring preparatory care (e.g., colonoscopy) or have a planned medical treatment (e.g., chemotherapy treatment) requiring care prior to or following treatment as determined by a Qualified Health	• Short-Term Pre-Procedure Housing

Clinical Need	Need Description	What CIS+ Services is the Member Eligible For?
	Professional.	
Short-Term Recuperative Care Need	A member must be at risk of institutionalization or in institutional care, which may include an acute care hospital, state mental health hospital, nursing facility, or other inpatient or institutional setting. **And**, a member must have ongoing physical or behavioral health needs as determined by a Qualified Health Professional that would otherwise require continued institutional care if not for receipt of recuperative care.	• Short-Term Recuperative Care • Pre-Tenancy Supports • Tenancy Sustaining Services
Short-Term Post-Hospitalization Housing Need	A member must be in institutional care, which may include an acute care hospital, state mental health hospital, nursing facility, or other inpatient or institutional setting. Institutional care settings do not include the emergency department. **And**, a member must have ongoing physical or behavioral health needs as determined by a Qualified Health Professional that would otherwise require continued institutional care if not for receipt of Short-Term Post-Hospitalization Housing.	• Short-Term Post-Hospitalization Housing • Pre-Tenancy Supports Tenancy Sustaining Services

In addition to the eligibility criteria described above, Health Plans are responsible for ensuring that Medical Respite is clinically appropriate for the member. See the Medical Respite Section for more detail.

5. Health Plan and CIS+ Provider Roles

Health Plans are responsible for CIS+ benefit administration. Successful administration of the CIS+ benefit will require plans to collaborate with a range of stakeholders, including CIS+ Providers. The main activities associated with the CIS+ program and a high-level summary of Health Plan and CIS+ Provider roles in that activity are outlined in Table 3*: Health Plan and Provider Responsibilities*. CIS+ Provider responsibilities associated with each benefit are outlined in Appendix A.

Table 3: Health Plan and Provider Responsibilities

Task	Health Plan Role	CIS+ Provider Role
Member Identification	Responsible, see Identification of Potential CIS+ Members for more detail.	May provide community referrals to Health Plans on behalf of members.

Task	Health Plan Role	CIS+ Provider Role
Member Engagement	Responsible, member engagement for Housing Navigation may be delegated to CIS+ Providers.	May conduct member engagement for Housing Navigation, if authorized by the Health Plan.
Eligibility Verification	Responsible, see Eligibility Criteria for more detail.	May collect information used by the Health Plan for eligibility verification.
Service Authorization	Responsible, Health Plans must authorize CIS+ services based on clinical and social need.	Cannot make service authorization decisions.
Providing CIS+ Program Education and Soliciting Consent	Responsible, Health Plans may conduct education and solicit consent, or delegate to CIS+ Providers for Housing Navigation.	May conduct education and solicit consent from the member for Housing Navigation, if authorized by the Health Plan.
CIS+ Assessment	Responsible, Health Plans must ensure that members receiving Housing Navigation have a complete CIS+ Assessment (may delegate the task to a CIS+ Provider). See CIS+ Assessment for more detail.	May conduct the CIS+ Assessment, if authorized by the Health Plan.
Person-Centered Service Plan (PCSP) *(This includes CIS+ Action Plan, Health Action Plan, and Medical Respite PCSP)*	Responsible, Health Plans must complete a PCSP for each CIS+ member. Members receiving Housing Navigation must have at least the CIS+ Action Plan. Members receiving Medical Respite can meet PCSP requirements in one of three ways. Health Plans may delegate to providers to support the completion of PCSPs; however, Health Plans must review and approve PCSPs with delegated components. See Person Centered Service Plan and CIS+ Action Plan for more details.	May support the development of a PCSP, if authorized by the Health Plan.
CIS+ Benefit Coordination	Responsible, the Health Plan must engage CIS+ Providers and coordinate services.	Not responsible.
CIS+ Benefit Limit	Responsible, the Health Plan must	Not responsible.

Task	Health Plan Role	CIS+ Provider Role
Monitoring	track Medical Respite benefit limits.	
Service Provision	Responsible, the Health Plan must ensure that services are provided as documented in the member's PCSP.	Responsible, CIS+ Providers are responsible for service provision, as documented in the member's PCSP and as authorized by the Health Plan. See Appendix A for additional detail on benefit requirements and CIS+ Provider responsibilities.
Reporting	Responsible, see Reporting for more detail.	Responsible, see Reporting for more detail.
Provider Standard Verification	Responsible, the Health Plan must verify providers meet program requirements, including through documentation and site visits for Medical Respite Providers.	Responsible, the CIS+ Provider must ensure they meet program requirements and standards.
Claiming	Responsible, the Health Plan must pay CIS+ Providers.	Responsible, CIS+ Providers must submit a clean claim to the Health Plans.
Registration/Contracting	Responsible, the Health Plan must contract with CIS+ Provider and maintain an adequate CIS+ Provider network.	Responsible, CIS+ Providers must register with Medicaid and additionally contract with Health Plans.

QI Health and Community Care Services (CCS) Plan Roles

For Housing Navigation and Medical Respite, the CCS Plan administers the benefit for CCS members. For all other members, the QI Health Plan administers the benefit. In this context, references to "Health Plans" include both QI and CCS Plans for CCS members.

For Medical Respite, whichever entity receives the referral will be responsible for responding to the request, determining eligibility, and administering the benefit for the initial authorization period. Once the member is receiving Medical Respite, if the member has a CCS plan, the QI Health Plan should conduct a warm handoff and transition CIS+ benefit administration to the CCS plan.

Collaborative Team-Based Approach

MQD's preference for a team-based approach to the implementation of the CIS+ program remains unchanged and is re-emphasized. The Health Plans shall lead collaborative efforts to support provider agencies. Recommended collaboration includes orientation to and training on CIS+ implementation and monthly (at minimum) case conferences to discuss members enrolled

in the CIS+ program. Case conferences should be used as an opportunity to troubleshoot and resolve any implementation issues, as well as to facilitate members' engagement in CIS+. Additionally, case conferences are an opportunity for Health Plans to ensure CIS+ members' access to medical services and/or other QI benefits for which they are eligible. When utilized, the monthly Housing Navigation benefit payments shall include services provided by all Housing Navigation Provider team members.

All Health Plans are strongly encouraged to participate in the Homeless Management Information System (HMIS).

6. Other CIS+ Related Assessments

Some community providers may also complete the Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT) or the Matching to Appropriate Placement (MAP) tool. These assessments should be included in the CIS+ member assessment process for members eligible for HMIS and CES, but are not required by the CIS+ program. MQD recognizes that some of the questions on the MAP assessment are duplicative of questions asked in the CIS+ Action Plan. Therefore, as long as the MAP assessment has been conducted within 90 days of the CIS+ Action Plan development, data from the MAP assessment can be used to pre-populate duplicative questions on the CIS+ Action Plan.

The Health Plan shall review the member eligibility and/or assessment to identify CIS+ members who may additionally benefit from LTSS, Special Health Care Needs (SHCN) services, and CCS. If any of these needs are identified, the Health Plan will arrange for these additional assessments to be completed.

Initiating CIS+ Services: Service Planning, Referrals, Consent, and Assessments

7. Person-Centered Service Plan (PCSP)

Per the Section 1115 Demonstration approval, every member receiving CIS+ is required to have a PCSP. During the person-centered planning process, members shall be informed about all CIS+ services potentially available to them and the limits associated with each service. The PCSP shall document members' needs, what is important for them, individualized strategies and interventions for meeting those needs, and barriers to meeting those needs.

Health Plans may delegate completion of the PCSP to another entity (e.g., a hospital). Delegation must be documented, and the delegate must be able to educate the member on the full CIS+ program, including all benefits available and the benefit limits. Due to conflict-of-interest requirements, Health Plans may NOT delegate completion of the PCSP for Medical Respite to a Medical Respite Provider. While the Health Plan or its delegate may conduct the person-centered planning process, Health Plans are ultimately accountable for this process and the authorization of CIS+ services based on members' eligibility and need. The person-centered

planning processes can occur during the same visit as when the member provides consent to participate in the CIS+ program.

Table 4 provides guidance on how Health Plans can meet PCSP requirements, based on the specific CIS+ service a member is receiving. In cases where multiple options are available, Health Plans shall choose the approach that not only satisfies the person-centered planning requirements but also best fits the member's individual needs or supports timely connection to services. For members receiving Medical Respite, a PCSP should be developed within 3 calendar days of admission to ~~a~~ Medical Respite, or within 3 calendar days of Health Plan authorization for members admitted before authorization is issued.

Members may have more than one PCSP, depending on their services and the programs they are enrolled in (e.g., an individual receiving both Housing Navigation and Medical Respite may have both a CIS+ Action Plan and a Health Action Plan (HAP) if the member opts for health coordination). Details of the PCSP requirement for Housing Navigation and the PCSP options for Medical Respite, are provided below.

Table 4: Minimum Requirements for Person-Centered Service Planning for CIS+ Services

CIS+ Services the Member is Receiving	Mandatory PCSP	Timeframe
Housing Navigation	(1) CIS+ Action Plan	Within forty-five (45) days from the start of the month in which the CIS+ Provider begins billing for Housing Navigation
Medical Respite	At least one of the following: (1) CIS+ Action Plan (2) Health Coordination Services with Health Action Plan and CIS+ Assessment (3) Medical Respite Person-Centered Service Plan	Within 3 calendar days of admission to ~~a~~ Medical Respite (or of Health Plan authorization, for members admitted before authorization) ~~Facility~~

Medical Respite PCSP Option 1: CIS+ Action Plan

All members receiving Housing Navigation shall have a CIS+ Action Plan. See the CIS+ Action Plan section for full details.

Medical Respite PCSP Option 2: Health Coordination Services (HCS), resulting in a Health Action Plan, and CIS+ Assessment

Health Plans can leverage Health Coordination Services and a Health Action Plan as the person-centered planning process to connect a member to Medical Respite services. HAPs being used in this manner must include service planning for CIS+, which can be completed by including the CIS+ Assessment as an addendum to the Health and Functional Assessment (HFA). Members are encouraged, but not required, to participate in Health Coordination Services.

Medical Respite PCSP Option 3: Medical Respite Person-Centered Service Plan

Health Plans may use the Medical Respite PCSP in Appendix J for members receiving Medical Respite services. Because developing a CIS+ Action Plan or HAP may be time-intensive and challenging for members in an institution or recently discharged to complete, Appendix J allows Health Plans to develop a streamlined PCSP with the member. This option may help facilitate the timely development of PCSPs within the required timeframe. ~~3 calendar days of Medical Respite admission~~

The complete Medical Respite PCSP should meet the following minimum standards:

- Identifies the member's needs, individualized strategies and interventions for meeting those needs, and barriers to meeting those needs;
- Is developed in consultation with the member and the member's chosen support network, as appropriate; and
- Is reviewed and revised as appropriate at least every 12 months, when the member's circumstances or needs change significantly, or at the member's request.

8. Identification of Potential CIS+ Members

Referrals for CIS+ will come through different entities, depending on where the member is engaged and/or identified as potentially eligible for CIS+. Entry points into CIS+ include:

a. Health Plan data analyses for Homelessness Z-Code (Z59 series), or other indications of homelessness (e.g., Z55-Z65 series used to document persons with potential health hazards related to socioeconomic and psychosocial circumstances, and other indicators of unusual utilization patterns or address information indicative of housing instability);
b. Health Plan analyses of utilization data on members who are identified to be homeless or potentially homeless to establish health needs-based criteria;
c. Health Plan members who were previously identified as homeless or at risk for homelessness but were assigned a status of H7 (CIS+ – Beneficiary Lost to Follow Up) or H8 (CIS+ – Unable to Contact) and subsequently disenrolled from the program;
d. Access to and verification of homelessness status within HMIS. MQD encourages Health Plans to establish data sharing agreements with HMIS that enable automated member-matching;
e. Member-matching against the HMIS/Coordinated Entry System (CES) By-Name List;
f. Welcome calls for new members/member surveys from Health Plan activities;
g. Quality improvement activities through Health Plan;
h. HFA assessments/re-assessments for members or other member engagement activities;
i. Referrals from Community Service Coordinators/Case Managers, or other healthcare

providers;

j. Referrals from current homeless agencies, independent living providers, DHS and Continuum of Care (CoC) Homeless Assistance Agencies, Hawaii Public Housing Authority (HPHA), Department of Health's (DOH) Alcohol and Drug Abuse Division (ADAD) and Adult Mental Health Division (AMHD);
k. Referrals from community-based organizations (CBOs), for example, food banks;
l. Medical provider referrals including, but not limited to, providers from inpatient, emergency department, nursing facility, primary care, community health centers, other clinical, and other institutional settings;
m. Referrals from MQD Medicaid eligibility workers, and other MQD staff;
n. Re-entry worker/system referrals for example from the Hawaii State Hospital (HSH), prisons, drug treatment facilities, etc.; and
o. Members, or their friends and family members.

Housing Navigation Reporting Reference

Health Plans are expected to identify potentially eligible CIS+ beneficiaries through referrals or health analytics, as described above. Upon being identified as potentially eligible for Housing Navigation, members shall be assigned status code H1 (CIS+ – Potentially Eligible) if outreach engagement authorization is pending further research by the Health Plan, or status code HA (CIS+ – Potentially Eligible with Outreach Engagement Authorized) if outreach engagement for Housing Navigation is authorized by the Health Plans. Authorization decisions are made internally by Health Plans. The status code should reflect the member's status at the time of code assignment. For example, a member may move directly into status code HA without being assigned H1 depending on Health Plan authorization processes. In these types of cases, the Health Plan would not need to submit "by-passed" status codes to MQD.

9. CIS+ Referral and Eligibility Confirmation

CIS+ Referral

There are two referral forms for the CIS+ programs, described in detail below:

1. CIS+ Referral Form (Appendix B): Any member, individual, or organization can use this form to refer members for any CIS+ service.
2. Medical Respite Authorization Form (Appendix I): For Health Plans to authorize Medical Respite services, a Qualified Health Professional must review and sign the Medical Respite Authorization Form. See the Medical Respite section for more details.

CIS+ Referral Form

The CIS+ Referral Form is provided in Appendix B.

Given multiple points of entry into CIS+, completion of the CIS+ Referral Form is not mandatory;

rather, the form is provided as a tool to enable standardized data collection from community-based referral sources. Additionally, while MQD does not require completion of the CIS+ Referral Form, Health Plans must make arrangements to capture the referral/identification source for all CIS+ beneficiaries in order to comply with required reporting elements.

CIS+ Referral Forms shall be sent to the member's QI Health Plan, CCS Plan, or to MQD/Health Care Services Branch (HCSB) if the member's Health Plan is unknown. MQD will forward any CIS+ Referral Forms received to the member's current Health Plan. Referrals should be as complete as feasible before submission; however, referring parties should be encouraged to submit the referral form and any available documentation regardless of the availability of complete information. It is the Health Plan's responsibility to obtain and assure completeness of information and documentation to confirm eligibility for CIS+.

If the member is identified to be in immediate danger, or is currently a threat to self or others, the Health Plan shall take immediate action to provide resources to stabilize the members, regardless of eligibility for CIS+.

Eligibility Confirmation

Upon referral notification, the Health Plan will independently verify if the member meets eligibility criteria. For any new external referrals for Housing Navigation received, or members identified as potentially eligible through any internal source, the Health Plan shall have no more than 30 days from the receipt of the referral to determine eligibility and authorize initial engagement and Pre-Tenancy Supports/Tenancy Sustaining Services. To minimize service delay, Health Plans are encouraged to determine eligibility and authorize initial engagement and Pre-Tenancy Supports/Tenancy Sustaining Services within fifteen (15) days after receipt of the external referral. For institutionalized members, Health Plans should complete the eligibility confirmation before discharge.

See the Medical Respite section for more detail on Medical Respite eligibility confirmation.

Eligibility Verification Backlogs

The Health Plan shall develop a plan to process and clear the backlog of any members identified as potentially eligible (e.g., (H1)) for CIS+ through any internal source, including those identified through Health Plan analytics or in its systems at the start of implementation. The backlog plan shall include how the plan will prioritize members with more complex physical or behavioral health needs using a risk-based algorithm or other predictive analytics tool. The Health Plan's backlog and plan, including timeline, for clearing any backlogs of existing referrals, shall be described as part of quarterly report submissions.

Appeals and Grievances

If the Health Plan concludes that the member does not meet eligibility criteria for CIS+, the member requesting CIS+ services must be provided information on how to appeal the decision. The Health Plan shall incorporate a protocol for CIS+ appeals into its overall member and provider grievance and appeals processes.

Housing Navigation Reporting Reference

Health Plans are expected to identify potentially eligible CIS+ beneficiaries through data analytics at least once per quarter. Data analytics includes members who were previously at any stage of CIS+, including beneficiaries who were disenrolled from the program (especially when disenrolled due to lack of contact). If these members are re-identified and potentially eligible for CIS+, they shall be assigned a status code of H1 (CIS+ – Potentially Eligible) or HA (CIS+ – Potentially Eligible with engagement authorized). Additionally, referrals from other QI Health Plan staff are expected to be received and evaluated on an ongoing basis.

As the QI Health Plan confirms eligibility or ineligibility of the member for CIS+, the member's CIS+ status shall be updated to H2 (CIS+ – Contacted – Confirmed Eligible) or H3 (CIS+ – Contacted – Not Eligible).

10. CIS+ Member Consent

The CIS+ Member Consent Form is provided in Appendix C and can be used for all CIS+ services and remains valid as long as the member is actively enrolled in CIS+. If a member disenrolls or stops receiving CIS+ services, a new CIS+ Member Consent Form must be signed upon re-enrollment. Members who begin receiving additional CIS+ services while remaining enrolled do not need to sign a new consent form, as the original consent applies to all CIS+ benefits.

Once a member is deemed eligible for CIS+, the Health Plan or CIS+ Provider shall contact the member and obtain consent to participate in the program. If the member is in immediate need of Medical Respite services, the Health Plan should contact the member and obtain consent as soon as feasible. See Appendix H for a depiction of when to use the CIS+ Member Consent Form.

As part of the consent process, the Health Plan or its delegate shall explain the program and services, provide the member an opportunity to ask any questions, and provide adequate information to support the member in making an informed choice. The member shall be invited to engage any additional advocates of their choosing to participate in consent, assessment, and/or planning process. The person-centered planning process may also occur during the same visit, after consent is obtained.

Consent for Housing Navigation

For Housing Navigation, Health Plans and CIS+ Providers are encouraged to obtain consent within ten (10) days after engagement has been authorized by the Health Plan.

Consent for Medical Respite Services

Due to the time-sensitive nature of Medical Respite services, the Health Plan or their designee should obtain consent as soon as possible, within a maximum of 10 days.

- *Members in an institution:* Consent must be obtained prior to discharge.
- *Members with upcoming procedure:* If the member requires Short-Term Pre-Procedure Housing in less than 10 days, consent should be obtained as soon as possible to avoid delays in care.

Housing Navigation Reporting Reference

When the member moves into H2 (CIS+ – Confirmed Eligible for Housing Navigation), the Health Plan (or authorized provider) may then locate and meet with the member to obtain consent for CIS+. Signing of the consent form shall transition a member's CIS+ status from H2 (CIS+ – Confirmed Eligible) to HC (CIS+ – Eligible Consented). HC should be used for eligible members who have signed a consent to participate in the program. These members are considered enrolled in CIS+ at time of consent. Then, members in status code HC can move to H5 (CIS – Pre-Tenancy Supports) or H6 (CIS+ – Tenancy Sustaining Services). Members who refuse to provide consent to participating in CIS+ shall be transitioned to a CIS+ status of H4 (CIS+ – Eligible Refused). The Health Plan shall capture all information on the consent form for reporting to MQD.

11. Housing Navigation Post-Consent Transition Period

For Housing Navigation, MQD recognizes that there is a period of transition post-consent during which the member is enrolled in CIS+ but awaiting completion of the CIS+ Assessment and/or HFA. To ensure continued member engagement, establish trust, eliminate barriers to services, and prepare for the delivery of Pre-Tenancy Supports and Tenancy Sustaining Services, preparatory activities which further the pursuit of stable housing may be delivered during this transition period under HCPCS code H0044.

12. CIS+ Assessment

The CIS+ Assessment is provided in Appendix D.

This tool is a modified version of the CIS+ Member Assessment and Re-Assessment Tool provided in QI-2314C as Appendix D. The document has been updated to also support the assessment of need for Medical Respite services, among other minor edits.

The purpose of the tool is to collect systematic self-reported information and document various housing and related needs from members enrolled in CIS+, along with observations by the assessor, to support identification of social and other clinical needs at the point of care.

The CIS+ Assessment has four sections:

- Part I: Agency information
- Part II: Member information
- Part III: Preferences
- Part IV: Housing readiness

The CIS+ Assessment shall be completed at member enrollment or re-enrollment into CIS+.

The Health Plan or CIS+ Provider shall have 45 days from the start of the month in which the CIS+ provider begins billing for Housing Navigation to complete the CIS+ Assessment and CIS+ Action Plan (see CIS+ Action Plan). Assessments completed by a CIS+ Provider shall be submitted to the Health Plan within 30 days of completion.

If during the assessment process, the member is identified to be in immediate danger, or is currently a threat to self or others, the Health Plan shall take immediate action to provide resources to stabilize the members, regardless of the member's prioritization or acuity score to receive CIS+ services.

Reporting Reference

Health Plans shall be required to submit data collected in the CIS+ Assessment as part of reporting requirements. Therefore, the tool provided in Appendix D may be operationalized as Health Plans see fit to ensure data collection for reporting to MQD.

13. CIS+ Action Plan

The CIS+ Action Plan is provided in Appendix E. The CIS+ Action Plan is required for members receiving Housing Navigation and is one of three PCSP tools that a Health Plan can use for members receiving Medical Respite (see the Person Centered Service Plan section for more details). This tool is a modified version of the CIS+ Health Action Plan provided in QI-2314C as Appendix E.

The CIS+ Action Plan shall capture the services needed and plan for provision of these services to the member. The CIS+ Action Plan may be used as a stand-alone document to plan CIS+ services for members who opt out of health coordination services. Health Plans should continue to engage members who opt out of health coordination services to encourage them to accept health coordination.

The Health Plan or CIS+ Provider shall have 45 days from the first day of the month in which the CIS+ Provider begins billing for Housing Navigation to complete the CIS+ Assessment and CIS+ Action Plan. The CIS+ Action Plan must be reviewed with, agreed to, and signed by the member and preparer before it is considered final. When the need for additional CIS+ services is identified, the CIS+ Action Plan should be reviewed by the Health Plan, which has the authority to authorize other CIS+ services.

The CIS+ Action Plan completed by a CIS+ Provider shall be submitted to the Health Plan within 30 days of completion. The CIS+ Action Plan shall be reviewed and updated every three months, at the member's request, or when the member's circumstances or needs change significantly.

The results of the CIS+ Assessment shall guide the development of the CIS+ Action Plan. The CIS+ Action Plan shall be developed through a person-centered process in consultation with the member and the member's chosen support network, as appropriate. CIS+ service planning shall

be conducted with the member, and the CIS+ Action Plan shall capture the members' CIS+ services and support needs. The CIS+ Action Plan has eight (8) sections:

Part I: Agency information
Part II: Member information
Part III: Member health and well-being
Part IV: Member housing
Part V: Services/resource utilization
Part VI: Person-centered housing goals
Part VII: Other interviewer notes and observations
Part VIII: Discharge from CIS+

The types of supports identified should be person-centered and additionally reflect the goals of the CIS+ program, which are to improve health outcomes and decrease healthcare costs of members with complex health needs that are compounded by homelessness or housing instability. As such, re-engagement in medical care, and supports to stabilize and/or fortify the member's ability to manage their health, are critical to achieving the goals of CIS+. Also, CIS+ members are particularly vulnerable to losing Medicaid eligibility during re-determination due to incomplete or inaccurate contact information and/or non-submission of required documentation. As a result, the CIS+ Action Plan shall include CIS+ Provider actions to support the member in preventing lapses in Medicaid eligibility tied to logistical, as opposed to valid, reasons.

The CIS+ Action Plan shall additionally address identified barriers and member goals; supports needed for the member to find housing, live successfully in the community, and achieve the highest level of independence possible; services provided by CIS+ and services provided by community-based resources; and frequency/duration of planned services with the member.

Person-Centered CIS+ Crisis Plan and Eviction Prevention Plan

The CIS+ Action Plan should incorporate plans for crisis and eviction prevention, including language on:

1. Strategies to address behaviors or situations that may threaten housing or health, based on past experiences.
2. Actions the member will take to prevent or avert a crisis or eviction.

When applicable, the CIS+ Provider should coordinate and collaborate on the crisis plan and eviction prevention plan with the member's Health Plan.

14. Medical Respite Provider Discharge ~~Reporting~~ Form

Medical Respite Providers should complete Appendix L – Medical Respite Provider Discharge ~~Reporting~~ Form for each member who leaves Medical Respite. Forms should be shared with the member's Health Plan within 15 days of a member leaving Medical Respite. Health Plans will report this information to MQD through the Medical Respite Quarterly Report.

15. Forms

Health Plans and CIS+ Providers shall use the following forms to collect data (see Table 5). CIS+ members who accept Health Coordination must have an HFA and HAP completed. The CIS+ Assessment may be used as a stand-alone document to identify the CIS+ needs of members who opt out of Health Coordination Services.

Table 5: CIS+ Forms

Form	Version	Cadence	Location
CIS+ Referral Form (optional)	Updated July 1, 2026	Anytime, for any benefit	Appendix B
CIS+ Consent Form	Updated July 1, 2026	At enrollment and re-enrollment, before services are provided	Appendix C
HFA and HAP, if applicable	Refer to Health Plan Manual	Optional if member opts for health coordination services; consider for members eligible for Medical Respite	Unchanged
CIS+ Assessment	Updated July 1, 2026	At enrollment and re-enrollment, for Housing Navigation	Appendix D
CIS+ Action Plan	Updated July 1, 2026	Every three months, at the member's request, or when the member's circumstances or needs change significantly, for Housing Navigation	Appendix E
Medical Respite Authorization Form	Updated November 2, 2026	When authorizing or extending Medical Respite benefits, determining the member's level of care, and verifying ongoing Medical Respite clinical appropriateness as described in the Medical Respite section of this guidance	Appendix I
Medical Respite Person-Centered Service Plan (PCSP)	New January 2, 2026	When developing a PCSP for a member who is eligible for Medical Respite benefits	Appendix J
Medical Respite Provider Attestation Form	Updated November 2, 2026	Optional, if chosen to use to become a Medicaid-registered Medical Respite Provider. Part 6 is required for Medical Respite Providers requesting eligibility for the MQD Level 3/4 rate	Appendix K
Medical Respite	New July 1, 2026	Medical Respite Providers should	Appendix L

Form	Version	Cadence	Location
Provider Discharge ~~Reporting~~ Form		complete and share this form with the member's Health Plan within 15 days of the member leaving Medical Respite	

The retention schedule for the above documents should comply with all requirements outlined in Contract RFP-MQD-2021-008, Section 14.5.

The CIS+ Provider shall maintain a copy of all forms and make a copy available to the member for review upon request. Additionally, the forms shall be shared with the member's Primary Care Provider and care team (if applicable).

The CIS+ Referral Form, CIS+ Assessment, and CIS+ Action Plan shall be completed within the maximum timeframes as detailed in the CIS+ Activity Timeframes section. MQD encourages Health Plans to take steps to have these various forms completed sooner than the stated maximums. Where possible, Health Plans are encouraged to have multiple forms completed during a single member visit.

Reporting Reference

Information on services and supports authorized via the CIS+ Action Plan, as well as progress on the provision of these services shall be captured by the Health Plan and submitted to MQD as part of reporting requirements.

CIS+ Providers should continue to collect data required by their respective Health Plan contracts in anticipation of audit and/or reporting requirements.

Authorization, Billing, and Payment

16. Authorization, Billing Codes, and Rates

For authorization, billing, and payment of any CIS+ service, the following criteria apply:

- An authorization from the member's Health Plan is required before CIS+ services are provided or billed by a CIS+ Provider; service-level guidance is provided below for any potential retroactive payment of services rendered prior to obtaining an authorization, if applicable.
- CIS+ Providers must submit clean claims to the member's Health Plan, meaning that the claim contains no errors, omissions, or discrepancies, and is submitted in the proper format with all necessary patient and service information, correct codes, and required supporting documentation, as applicable, to enable timely reimbursement for services rendered.
- Payment for other housing or housing-related supports that fall outside of those listed in Appendix A is not allowed as a CIS+ benefit and therefore will not be reimbursed

within the Medicaid program.

- CIS+ Providers must be contracted by the Health Plan to bill and receive payment for providing CIS+ services (see CIS+ Provider Medicaid Registration, and CIS+ Provider Qualifications and Contracting Requirements for additional detail).

Services shall be billed to the Health Plan using one of the HCPCS codes provided in Table 6 below. The table describes the HCPCS codes to be used for billing and encounter data submission purposes, along with rates of reimbursement if paid by MQD on an FFS basis. Health Plans will be reimbursed by MQD based on encounter data submitted using the approved HCPCS codes.

Table 6: CIS+ Service Categories and HCPCS Codes

Service Category	Service Description	HCPCS Code	~~Proposed~~ Rate
CIS+ Engagement			
Member Engagement (pre-consent)	• Member engagement • Obtain member consent for CIS+ participation	T1023	QI: One bundled payment $200 per member per month CCS: One bundled payment $50 per member per month
Housing Navigation (after CIS+ Consent Form is completed)			
Pre-Tenancy Supports OR Tenancy Sustaining Services	• Transition, collaboration, and documentation • CIS+ Assessment • CIS+ Action Plan (PCSP) • Pre-Tenancy Supports • Tenancy Sustaining Services	H0044	QI and CCS: One bundled payment $350 per member per month
Medical Respite			
Short-Term Pre-Procedure Housing	**Pre-Procedure Housing-benefit usage** Housing and support for members with a planned medical procedure requiring preparatory care	S5151 with modifier SC	MQD Level 1/2 – QI and CCS: $274 per member per day
		S5151 with modifier U1	MQD Level 3/4 – QI and CCS: $412 per member per day
	Post-Procedure Housing benefit usage Housing and support for members with a planned medical procedure requiring care following treatment	S5151 with modifier SE	MQD Level 1/2 – QI and CCS: $274 per member per day
		S5151 with modifier U2	MQD Level 3/4 – QI and CCS: $412 per member per day

Service Category	Service Description	HCPCS Code	~~Proposed~~ Rate
Short-Term Recuperative Care	Housing and clinically oriented support for members with ongoing medical and psychiatric needs	S9125 with modifier 22	MQD Level 1/2 – QI and CCS: $274 per member per day
		S9125 with modifier UA	MQD Level 3/4 – QI and CCS: $412 per member per day
Short-Term Post-Hospitalization Housing	Housing and limited support for members in continued recovery from a physical, psychiatric, or substance use condition following discharge or exit from an institution	S9125 with modifier SC	MQD Level 1/2 – QI and CCS: $274 per member per day
		S9125 with modifier U7	MQD Level 3/4 – QI and CCS: $412 per member per day

Below, please find details on authorization, billing, and payment for each CIS+ Housing Navigation and Medical Respite service.

17. Housing Navigation Authorization, Billing, and Payment Detail

An authorization from the Health Plan is required before services are provided or billed by the CIS+ Provider.

- If the CIS+ Provider submits a claim for CIS+ engagement without an authorization, the claim will be held until eligibility is determined. Once eligibility is established, the Health Plan may issue a retroactive T1023 authorization, up to one month prior.
- If the CIS+ Provider submits a CIS+ Consent Form without an authorization, the consent will be held until eligibility is determined. Once eligibility is established, the Health Plan may issue a retroactive H0044 authorization, up to one month prior.

CIS+ Providers registered with Medicaid may then bill the Health Plan (or the CCS Health Plan if the member is a CCS member) using their 6-digit Med-QUEST Provider ID. Submission of a clean claim to the Health Plan shall result in a per-member-per-month (PMPM) bundled payment to the CIS+ Provider. Housing Navigation Providers are limited to one monthly bundled payment per member for either the engagement services category or the Housing Navigation category (Pre-Tenancy Supports/Tenancy Sustaining Services). Payments will reflect the full PMPM amount and will not be prorated. Claims payment shall align with standard claims payment timeframes.

Health Plans should not routinely request case documentation as a pre-payment requirement for each claim. In lieu of pre-payment documentation requests, Health Plans may implement routine post-payment reporting and auditing of provider documentation as part of provider oversight activities.

Prior authorization turnaround times shall align with standard authorization turnaround times

outlined in Contract RFP-MQD-2021-008, Section 5.2.B. To minimize the risk of delay in member service and provider payment, prior authorization for initial engagement (T1023) and future Pre-Tenancy Supports/Tenancy Sustaining Services (H0044) should be issued at the same time. Payment for future Pre-Tenancy Supports/Tenancy Sustaining Services (H0044) is contingent on CIS+ member consent and eligibility confirmation.

Reporting Reference

Health Plans will submit daily CIS+ member files to update MQD on CIS+ status code changes (reference memo QI-2003B). The Health Plan shall collect more detailed data, in addition to claims data, to track the CIS+ Provider's progress on completing or providing the member-specific services and support needs identified in the CIS+ Action Plan. This data shall be reportable to MQD as part of reporting requirements using the updated CIS+ Integrated Reporting Template and other upcoming reports, if applicable.

Monthly Engagement Services

Health Plans will authorize PMPM CIS+ engagement, screening and/or eligibility activities in a minimum of one-month increments. It is generally expected that engagement will not extend beyond three months; however, it remains at the discretion of Health Plan to determine appropriate duration. The CIS+ Provider's engagement services may be billed to the Health Plan using HCPCS code T1023 for services related to locating the member, establishing rapport, conducting screening to determine program eligibility, and/or completing the program consent (or refusal) process.

Monthly Housing Navigation (Pre-Tenancy Supports/Tenancy Sustaining Services)

Health Plans will authorize PMPM payments for Pre-Tenancy Supports/Tenancy Sustaining Services in three-month increments. After the CIS+ Consent Form is completed, monthly supports services may be billed to the Health Plan using HCPCS code H0044 for Pre-Tenancy Supports and Tenancy Sustaining Services listed in Appendix A. The Health Plan has the overall responsibility of assuring that services provided to the member are in alignment with the authorized services, and that the member is making expected progress. If the Health Plan changes CIS+ Providers, the Health Plan shall support the transition of care. If a CIS+ Provider seeks to discharge a member from their care, that CIS+ Provider should continue delivery of authorized services until another CIS+ Provider accepts the member and receives authorization from the Health Plan or until the current authorization expires, whichever is sooner.

Place of Service Coding

Claims submitted by CIS+ Provider for CIS+ Engagement and CIS+ Housing Navigation shall include the appropriate Place of Service (POS) codes to indicate setting and face-to-face (or non-face-to-face) services. Examples include POS 04 (homeless shelter), POS 12 (home), POS 14 (group home), POS 15 (mobile unit), POS 16 (temporary lodging), and POS 27 (outreach site/street). These are examples of short-term accommodations that are not identified in any other POS code.

Effective October 1, 2023, CMS defined new POS code 27 as "A non-permanent location on the street or found environment, not described by any other POS code, where health professionals provide preventive, screening, diagnostic, and/or treatment services to unsheltered homeless individuals."[3] MQD provided additional related guidance in Street Medicine Memo QI-2327A, FFS-23-13A, CCS-2310A.

POS 99 (other unlisted facility) should not be routinely used for CIS+ services. POS 99 should only be used as a last resort and only if appropriate by CMS criteria.

Housing Navigation rendered via telehealth shall be billed as outlined in memorandum QI-2338.

18. Medical Respite Authorization, Billing, and Payment Detail

Medical Respite services are reimbursed using one of two ~~on a~~ per diem bundled rates (MQD Level 1/2 or MQD Level 3/4) that cover~~s~~ all services described in Appendix A, including transportation. Details on reimbursement processes for each of the three Medical Respite services are provided below.

~~Authorization from a member's Health Plan is required before services are provided or billed by the provider.~~ CIS+ Providers registered with Medicaid may ~~then~~ bill the Health Plan using their 6-digit Med-QUEST Provider ID. Providers should follow all standard billing practices when submitting a claim, including adding a POS code when required. Submission of clean claim to the Health Plan shall result in per diem bundled payment to CIS+ Providers for Medical Respite services.

Claiming detail:

- Payments will reflect the full per diem amount and will not be prorated.
- Claims payment shall align with standard claims payment timeframes.
- Prior authorization turnaround times shall align with standard authorization turnaround times outlined in Contract RFP-MQD-2021-008, Section 5.2.B.

If a CIS+ Medical Respite Provider seeks to discharge a member from their care prior to completion of the authorized service, that provider should continue delivery of authorized services until another provider accepts the member and receives authorization from the Health Plan or until the current authorization expires, whichever is sooner. Prior authorization for Medical Respite services should be completed as soon as possible to avoid delays in care.

If a member leaves ~~a~~ Medical Respite but wishes to return during the period originally authorized by the Health Plan, they may do so. For example, if the Health Plan authorized 30 days of Short-Term Post-Hospitalization Housing, the member could leave after 10 days then return on day twenty (20) of the authorization period to receive the last 10 days of the benefit, since this is still within the authorized 30-day ~~one-month~~ period. MQD recognizes that there may be operational barriers to members receiving services again, for example, the Medical

[3] Centers for Medicare and Medicaid Services (CMS). Place of Service Code Set. https://www.cms.gov/medicare/coding-billing/place-of-service-codes/code-sets

Respite Provider may not have a bed available. If a bed is unavailable with the original Medical Respite Provider, the Health Plan may attempt to find placement for the member with another Medical Respite Provider. Once the authorization period ends, the member is no longer eligible to return to Medical Respite.

~~At a later date, MQD will explore a tiered rate structure for Medical Respite services based on NIMRC's framework for level of care needs and/or associated standards.~~

Medical Respite Service Duration Limits

The Health Plan shall only authorize a combined total of 6 months of Medical Respite services in a rolling 12-month period. Additional service-specific duration limits apply.

Per-Diem Short-Term Pre-Procedure Housing

Health Plans will authorize Short-Term Pre-Procedure Housing for clinically appropriate durations, based on the information provided by a Qualified Health Professional in the Medical Respite Authorization Form and follow-up communication. Short-Term Pre-Procedure Housing stays will be authorized before a planned medical procedure or treatment for no more than 7 days, and for no more than 3 days for related post-procedure or post-treatment stays. While the service is named "Short-Term Pre-Procedure Housing," pre-procedure and post-procedure housing use different HCPCS code modifiers. For services provided before the planned procedure or treatment, Medical Respite Providers may bill the member's Health Plan using HCPCS code S5151 with modifier SC at the lower intensity (MQD Level 1/2) rate, or with modifier U1 at the higher intensity (MQD Level 3/4) rate when the requirements in the Medical Respite Levels of Care section are met. For services provided after the planned procedure or treatment, Medical Respite Providers may bill using HCPCS code S5151 with modifier SE at the lower intensity (MQD Level 1/2) rate, or with modifier U2 at the higher intensity (MQD Level 3/4) rate when the requirements in the Medical Respite Levels of Care section are met.

Per-Diem Short-Term Recuperative Care

Health Plans will authorize per diem Short-Term Recuperative Care services for clinically appropriate durations, based on the information provided by a Qualified Health Professional in the Medical Respite Authorization Form and follow-up communication. Health Plans will authorize between 7 and 90 days of Short-Term Recuperative Care at a time. Members may receive no more than 90 days of continuous Short-Term Recuperative Care. After services are provided, Medical Respite Providers may bill the member's Health Plan using HCPCS code S9125 with modifier 22 at the lower intensity (MQD Level 1/2) rate, or with modifier UA at the higher intensity (MQD Level 3/4) rate when the requirements in the Medical Respite Levels of Care section are met.

Per-Diem Short-Term Post-Hospitalization Housing

Health Plans will authorize per diem Short-Term Post-Hospitalization Housing for clinically appropriate durations, based on the information provided by a Qualified Health Professional in the Medical Respite Authorization Form and follow-up communication. Health Plans will

authorize, at a minimum, 7 days of Short-Term Post-Hospitalization Housing. After services are provided, Medical Respite Providers may bill the member's Health Plan using HCPCS code S9125 with modifier SC at the lower intensity (MQD Level 1/2) rate, or with modifier U7 at the higher intensity (MQD Level 3/4) rate when the requirements in the Medical Respite Levels of Care section are met.

Reporting

19. Reporting

Health Plans are required to collect and report data from CIS+ Providers for program monitoring, CMS reporting, and evaluating the QUEST Integration Section 1115 Demonstration.

Health Plans should refer to the Health Plan Manual – Part III Reporting Guide, for the most recent version of the CIS+ Report, Medical Respite Report, and other reporting requirements. As always, plans should monitor the Health Plan Manual updates on a quarterly basis. The CIS+ Report and the Medical Respite Report are due quarterly, on the following schedule: January 31, April 30, July 31, and October 31.

Updated CIS+ Reporting

MQD plans to release an updated CIS+ Housing Navigation report in a future amendment. Health Plans shall continue reporting on the current draft and follow contractual timelines around implementing any future report updates. Health Plans and CIS+ Providers are responsible for collecting and reporting on more granular service utilization for members receiving Pre-Tenancy Supports and Tenancy Sustaining Services beyond encounter data.

Medical Respite Reporting

MQD released a new quarterly report to track Medical Respite data on April 1, 2026. Health Plans shall require CIS+ Providers to submit Appendix L – Medical Respite Provider Discharge Form upon a member's exit from Medical Respite. The questions in the Medical Respite Provider Discharge Form align with the Medical Respite Report.

MQD Learning Communities

20. MQD Learning Communities and Rapid Cycle Assessments

Health Plans shall participate in "learning communities" with CIS+ Providers and the State to ensure that Health Plans and providers are sharing and adopting best practices throughout the duration of the CIS+ program. The frequency of these "learning communities" may vary; for example, they may be more frequent when necessary, such as during the initial rollout of new CIS+ services.

If indicated by MQD, Health Plans shall also participate in MQD-led rapid cycle assessments of the Health Plans' progress towards implementation and achievement of the desired goals and outcomes of CIS+. Forums identified herein shall be used to address ongoing Health Plan challenges and advance the CIS+ program towards quality measurement.

Provider Requirements

21. CIS+ Provider Medicaid Registration

Hawaii's Online Kahu Utility (HOKU) Medicaid registration is one step in the process to deliver CIS+ services. Registered Medicaid providers must also contract with Health Plans, which are required to ensure that providers meet additional requirements (see the Qualifications of CIS+ Providers & Contracting Requirements section for more details).

Housing Navigation Provider Medicaid Registration Requirements

Any new Housing Navigation Provider delivering CIS+ services must register with (HOKU) under the A3 Provider type. As part of HOKU enrollment, new providers must submit a confirmation letter from Partners in Care (PIC - Oahu) or Bridging the Gap (BTG – Neighbor Islands) indicating their participation in the homeless services network. Existing CIS+ Providers must be registered in HOKU with a provider type A3 or 77.

Medical Respite Provider Medicaid Registration Requirements

CIS+ Medical Respite Providers must also register with HOKU under provider type A8 (Medical Respite). The HOKU requirements of provider type A8 closely align with the requirements of provider type A3, but with additional requirements to ensure Medical Respite capability. Each Medical Respite Provider operating under a unique "Doing Business As" (DBA) must register under its own National Provider Identifier (NPI).

To qualify, A8 Providers must complete the following tasks:

1. Each Medical Respite site must demonstrate the ability to deliver Medical Respite services through one of the following three options.
   a. *National Institute for Medical Respite Care (NIMRC) Certification:* Proof of certification by NIMRC;
   b. *Documented Experience:* Evidence of providing Medical Respite services through public contracts (e.g., state, health plan, hospital, or city/county) for at least one year; or
   c. *MQD Approval:* Attestation that the provider meets the NIMRC Level 1 requirements for a Coordinated Care Model as well as the CIS+ Provider requirements. To do this, Medical Respite Providers must complete and share Appendix K.
2. Each organization must submit a confirmation letter from Partners in Care (PIC - Oahu) or Bridging the Gap (BTG – Neighbor Islands) indicating their participation in

the homeless services network. Confirmation letters are issued at the organizational level; therefore, only one letter is required for Medicaid provider enrollment. If a Medical Respite Provider operates multiple sites, the provider is required to submit only a single letter.

The three options to demonstrate ability to deliver Medical Respite services outlined above (1a, 1b, and 1c) are designed to encourage a wide provider network for Medical Respite implementation. In the future, MQD may consider limiting A8 Providers to those with NIMRC certifications. As such, MQD strongly encourages Medical Respite Providers to pursue NIMRC certification.

See Service Settings for guidance on Medical Respite Provider settings and Appendix A for Medical Respite Provider services standards.

22. CIS+ Provider Qualifications and Contracting Requirements

Health Plans shall enter into a provider contract with each of the CIS+ Providers that will be billing for services described in the Authorization, Billing and Payment section. Health Plans shall maintain or contract with a sufficient number of dedicated staff or contractors willing to gain knowledge, expertise and experience to implement CIS+ services for Medicaid members, as described in Provider Network Adequacy section.

Requirements for all CIS+ Providers

Health Plans are required to ensure that CIS+ Providers meet and maintain compliance with the minimum qualification requirements listed below. However, Health Plans may develop more stringent requirements beyond the minimum requirements.

CIS+ Providers must:

1. Have knowledge of principles, methods, and procedures of housing services covered under the CIS+ program, or comparable services meant to support individuals in obtaining and maintaining stable housing.
2. Maintain sufficient hours of operation and staffing to serve the needs of CIS+ participants.
3. Demonstrate their capabilities and/or experience with providing at least one CIS+ service, as described in Appendix A. Health Plans must review providers' capabilities and/or experience for each service under CIS+. CIS+ Providers may demonstrate these capabilities and/or experience through, for example:
    a. One or more years of demonstrated experience to provide the specified CIS+ service(s). In addition to direct service provision, demonstrated experience may also include community outreach, completing assessments, assisting members with applying for benefits, obtaining necessary documentation, and other relevant experience as determined by the Health Plans.
    b. Maintaining all necessary licenses, registrations, and certifications as required by applicable federal and state laws, and the Health Plans. All CIS+ Providers should

have relevant training for the CIS+ services they are providing, which may include specific training and education on common housing capabilities such as harm reduction, fair housing laws, and the Health Insurance Portability and Accountability Act (HIPAA).

c. Other methods deemed appropriate by the Health Plan.
d. Evidence of qualified service delivery and administrative staff, as determined at the Health Plan's discretion.

4. The ability to comply with applicable federal and state laws.
5. The capacity to provide culturally and linguistically appropriate service delivery by:
    a. Demonstrating a willingness and ability to draw on community-based values, traditions, and customs to devise strategies to better meet culturally diverse member needs, and to work with knowledgeable persons of and from the community in developing focused interactions, communications, and other supports.
    b. Providing services to people of all cultures, races, ethnic backgrounds, and religions, including those with limited English proficiency and/or disabilities, and regardless of gender, sexual orientation, or gender identity, in a manner that recognizes, affirms, and respects the worth of the individual member and protects and preserves the dignity of each.

During orientation, newly hired direct service providers are required to complete training in:

- Supportive Housing Best Practices in engagement and providing supportive services;
- Common Diagnostic and Statistical Manual of Mental Disorders (DSM)-V diagnoses in the CIS+ population and addressing them in Fair Housing;
- Harm Reduction principles;
- Housing Referrals and CES processes;
- HIPAA; and
- Medicaid documentation and false claiming.

Annually, providers must complete training in:

- Trauma Informed Care;
- HIPAA;
- Fair Housing; and
- Reporting and addressing Major Unusual Incidents/Adverse Events.

Housing Navigation Provider Additional Qualifications

The preferred qualifications for Housing Navigation Providers are listed in Table 7.

Table 7: Housing Navigation Provider Qualifications

Category	Preferred Qualifications for Housing Navigation Providers
Education	Bachelor's degree in a human/social services field

Category	Preferred Qualifications for Housing Navigation Providers
Experience	One year of case management experience, or one year of field experience with a homeless **or** transitional housing agency. Field experience may include community engagement; locating individuals on the street; completing assessments on homeless individuals; finding short- and long-term housing; and/or assisting individuals to apply for documents, benefits, and housing.
Skills	Knowledge of principles, methods, and procedures of services included under CIS+, **or** comparable services meant to support individuals to obtain and maintain residence in independent community settings.
Supervision	Staff supervision that helps to develop low barrier, assertive engagement skills, build member motivation, conduct thorough assessments, establish meaningful housing plans, ensure member and staff safety, and support self-care; a case review process to help staff problem-solve around particular management challenges and to inform assessments, housing plans, and discharges is also recommended.

Medical Respite Provider Additional Qualifications

In addition to the overall CIS+ Provider requirements, Health Plans must ensure that Medical Respite Providers are equipped to meet members' needs. Below is a list of facility and safety minimum qualifications that providers offering Short-Term Pre-Procedure Housing, Short-Term Recuperative Care, and/or Short-Term Post-Hospitalization Housing must meet. However, some members may need a higher level of service, and the Health Plan must ensure that the setting can meet the needed level of care.

A description of the responsibilities that Medical Respite Providers must be able to perform is available in Appendix A. Medical Respite Providers are not required to provide all three Medical Respite benefits; however, they must be able to fully meet the responsibilities associated with any benefits they choose to offer.

Facility environmental and safety minimum qualifications:

- Follows regulations for the storage, handling, security, and disposal of patient medications as described in HRS § 328-119;
- Adheres to NIMRC Standards for Medical Respite Care Programs ~~Providers~~ developed by the National Health Care for the Homeless Council; and
- Has written protocols on the following topics:
    - Reporting adverse events using the Adverse Event Report (AER) Form described in memo QI-2513;
    - Connecting members to physical and behavioral healthcare;
    - Connecting members to other needed benefits; and
    - Discharging individuals from Medical Respite, including a policy that members are given a minimum of 24 hours' notice prior to being discharged from the program (exceptions for administrative discharges as determined by admissions,

discharge, and program safety policies).

Medical Respite Providers approved for the MQD Level 3/4 rate must also meet the additional responsibilities for MQD Level 3/4 Medical Respite Providers in Appendix A, covering onsite medical/clinical monitoring and evaluation, medication management, behavioral health care, 24-hour program staffing, on-call medical support, and documentation and notification.

23. Health Plan Medical Respite Documentation Review and Site Visits

Health Plans are responsible for verifying that contracted Medical Respite Providers meet all applicable program requirements. This responsibility includes conducting site visits and reviewing Medical Respite Provider documentation to confirm compliance with required standards.

Only one Health Plan shall conduct a site visit for each Medical Respite Provider. Approval by one Health Plan shall constitute approval by all Health Plans. Medical Respite Providers may submit an approval notice from one Health Plan to other Health Plans with which they are contracted, and the receiving Health Plans shall accept the approval without requiring an additional site visit. This reciprocal acceptance process is intended to reduce administrative burden for both providers and Health Plans while ensuring consistent adherence to required standards.

Site Visit Timing

For each Medical Respite site with which a Health Plan is contracted, at least one site visit must be completed annually. For existing Medical Respite Providers that ~~are~~ registered with Medicaid in the first six months of program go-live, the initial site visit must occur within the first six months of initial guidance publication (January 1, 2026). For Medical Respite Providers that are not registered with Medicaid during the first six months of program go-live (by June 30, 2026), the initial site visit must be completed before any Medicaid members receive the Medical Respite benefit at that site.

Compliance Review and Site Visit Process

Health Plans are responsible for collaboratively designing a compliance review and site visit process that ensures that Medical Respite Providers meet CIS+ program requirements. Health Plans may use this policy guidance and Appendix K as the primary tools for assessing whether providers meet program requirements. Additional documentation or information may be requested as needed to complete the compliance review. Health Plans are also responsible for assessing whether a Medical Respite Provider seeking eligibility for the MQD Level 3/4 reimbursement rate meets MQD's requirements, as described in Appendix A and Part 6 of Appendix K. A Medical Respite Provider located in a rural area (designated by the Health Resources and Services Administration's Federal Office of Rural Health Policy) may request a waiver of the onsite psychiatric medication management requirement for MQD Level 3/4 in Appendix A from the Health Plan that conducts its compliance review. Waiver approval by one

Health Plan constitutes approval by all Health Plans. Telehealth satisfies the onsite requirement only for Medical Respite Providers with an approved waiver.

Approval Determination and Provider Notification

Following completion of the compliance review and site visit, the Health Plan must notify the Medical Respite Provider of the outcome. If the Medical Respite Provider is approved, the provider is authorized to deliver Medical Respite services to members enrolled in all Health Plans for a one-year approval period. Approval for the MQD Level 3/4 rate by one Health Plan constitutes approval by all Health Plans and remains in effect through the end of the Medical Respite Provider's one-year approval period. Medical Respite Providers may bill at the MQD Level 3/4 rate for services delivered on or after the date of Health Plan approval. If deficiencies are identified, the Health Plan must provide feedback describing the areas requiring correction, and the provider must remedy these issues before approval is granted.

Annual Renewal and Ongoing Compliance

Approved Medical Respite Providers are subject to an annual renewal requirement. Each year, providers must renew their approval through a site visit to confirm continued compliance with all applicable facility, programmatic, and policy requirements. For Medical Respite Providers approved for MQD Level 3/4, the annual renewal also covers Part 6 of Appendix K.

Medical Respite Providers and Health Plans should coordinate site visits and compliance reviews with sufficient lead time to allow for the identification and correction of minor deficiencies. This coordination helps ensure that providers maintain continuous approval and that members have uninterrupted access to high-quality Medical Respite services.

Medical Respite Providers approved for the MQD Level 3/4 rate must notify MQD and contracted Health Plans within 30 days of any change that affects their ability to meet the MQD Level 3/4 responsibilities in Appendix A. 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.

24. Provider Network Adequacy

CIS+ services must be provided to qualifying beneficiaries in a timely manner. Health Plans shall develop and maintain policies and procedures outlining the Health Plan's approach to managing provider shortages or other barriers to timely provision of the CIS+ services. At minimum, the Health Plans' policies should include:

- A description of the Health Plan's strategies to identify and contract with CIS+ Providers, including outreach strategies to expand provider participation.

- A defined internal escalation pathway for urgent cases where service delays could jeopardize member health.
- Policies for communicating clearly with beneficiaries when alternative providers or arrangements are needed.

25. Program Integrity Responsibility

Health Plans must ensure services paid for and covered under CIS+ were rendered, ~~and~~ properly billed for, and documented by CIS+ Providers. Health Plans shall follow existing program integrity responsibilities in the Health Plan contract regarding the following:

- Encounter Data Analysis
- Visit Verification Procedures
- Recoupment of Overpayments
- Suspension, Withhold, Sanctions and Termination Activities
- Auditing Compliance

As an example of program integrity responsibilities, Health Plans must ensure that members do not receive more than a combined ~~(~~6 months~~)~~ of Medical Respite in a rolling 12-month period.

Preventing Fraud, Waste, and Abuse

MQD is committed to maintaining strong program integrity and ensuring full compliance with all applicable federal Medicaid statutes, regulations, and demonstration requirements. All CIS+ program activities must align with Title XIX of the Social Security Act and implementing regulations, except where specific provisions have been expressly waived or identified as not applicable. This includes requirements related to the identification, investigation, and referral of suspected fraud, waste, and abuse (FWA). Consistent with federal requirements, MQD will maintain effective systems and safeguards to prevent, detect, and address FWA in the administration of services paid for and covered as part of CIS+ under the Section 1115 Demonstration and will provide CMS with documentation of these systems upon request.

MQD takes these responsibilities seriously and has made program integrity a core component of Medicaid program design and operations. This commitment is reflected in an existing, well-established approach to program integrity that governs activities across the program. For example, as described in detail in Section 12 of the State's QI Health Plan contract, Health Plans are required to implement and operationalize robust compliance programs, including designated compliance officers, formal compliance plans, and governance structures that elevate compliance oversight. Health Plans must routinely monitor their operations and submit detailed reports to the State on addressing FWA, including actions taken in response to suspected or confirmed misconduct. These requirements are complemented by State-led provider screening and enrollment processes and established procedures to investigate and refer potential fraud or abuse, including coordination with law enforcement when appropriate.

Importantly, these existing program integrity expectations apply fully to all services paid for and covered as part of the CIS+ program.

Building on this strong foundation, MQD will implement enhanced monitoring and oversight for services paid for and covered as part of the CIS+ program, consistent with CMS expectations for heightened internal controls. Minimum requirements for Health Plan and CIS+ Provider reporting, data sharing, monitoring, and escalation of potential FWA are described in the Reporting section of this memo. Additionally, MQD promotes a culture of accountability in which all partners share responsibility for safeguarding program resources. All entities participating in this initiative, including Health Plans and CIS+ Providers, are expected to actively support program integrity efforts by maintaining effective internal controls, monitoring for potential FWA, and promptly reporting concerns through MQD's established channels.

26. Documentation

All contacts and activities that assist a CIS+ member shall be documented by the CIS+ Provider or the Health Plan if the Health Plan performs those activities. The CIS+ Provider and/or the Health Plan shall document all engagement attempts to engage the member. The Health Plan shall work in collaboration with CIS+ Providers to track the provision of services.

Housing Navigation Documentation

Progress notes should follow principles of documentation generally accepted in the social work field, including, but not limited to, the following elements:

- Date, time, type of visit, method of contact (face to face or phone) and place of contact;
- A summary of issues addressed (e.g., independent living skills, family, income/support, food assistance, legal, medication, educational, housing, interpersonal, medical/dental, vocational, engagement in clinical and/or community resources and services);
- Member's response and status/ progress in view of housing support plan;
- CIS+ Provider's observations and impressions;
- Collaboration with social services and community-based organizations or natural supports, beyond the CIS+ and/or Health Plan staff;
- Any referrals or other follow up to implement or adjust CIS+ Action Plan; and,
- Signature or electronic signature using credentials, as applicable.

Medical Respite Documentation

Progress notes should follow principles of documentation generally accepted in the Medical Respite field, including, but not limited to, the following elements:

- Documentation of clinical care provided;
- Status updates on member health and progress;
- If applicable, collaboration with social services and community-based organizations or natural supports, beyond the CIS+ and/or Health Plan staff; and,
- A discharge summary, to be shared with the members' primary care provider and others

as applicable.

CIS+ Member Considerations: Member Rights, Disenrollment and Re-Enrollment

27. CIS+ Member Rights

Members receiving CIS+ services maintain all member rights established under 42 CFR §438 and other federal statutes, regulations, and the Medicaid State Plan. For members receiving CIS+ services, the following member rights must be maintained:

- CIS+ services must not be used to reduce, discourage, or jeopardize members' access to covered services;
- Members always retain their right to receive covered services on the same terms as would apply if CIS+ services were not an option;
- Beneficiaries who are offered or who utilize a CIS+ service retain all rights and protections afforded under 42 CFR Part 438;
- Members cannot be denied a covered service on the basis that the beneficiary is currently receiving CIS+ services, has requested those services, has previously qualified for or received those services, or currently qualifies or may qualify in the future for those services; and,
- Members cannot be required to receive CIS+ services.

28. Disenrollment and Re-Enrollment

Members may be disenrolled from the CIS+ program. When a member disenrolls from CIS+, the member's status code must be end dated and sent to MQD by the Health Plan. Reason codes may be added later. Members who exit the CIS+ program may be re-considered for identification and eligibility later. If re-entering CIS+, eligibility must be re-confirmed, and member consent must be re-obtained.

Possible Disenrollment Reasons

The member:

- Requests voluntary disenrollment – option to "opt out" of the CIS+ program;
- Moves into a licensed/certified HCBS home, therefore no longer meets criterion for CIS+ services;
- Loses Medicaid eligibility;
- Is identified by the CIS+ Provider or Health Plan as non-compliant with CIS+ requirements;
- Is lost to follow-up (i.e., with a status code of H7 or H8);
- Has been stably housed for at least 12 months without incident;
- Mutually agrees with the Health Plan that CIS+ services are no longer needed;
- Becomes incarcerated; or,

- Dies.

Housing Navigation Reporting Reference

To report a CIS+ eligible member in CIS+ status code of either H5, or H6, as being lost to follow up (CIS+ status code H7), MQD is requiring that at least three unsuccessful attempts to reach the member in the last three months be made by a Health Plan or their designee. To report a potentially eligible member as being unable to contact (CIS+ status code H8), MQD is requiring that at least three unsuccessful engagement attempts in the last six months be made by a Health Plan or their designee to engage the member. These unsuccessful attempts to reach the member are to be documented in the member record. In these instances, the Health Plan shall submit a status code of H7 (CIS+ – Enrolled Lost to Follow Up) or H8 (CIS+ – Potentially Eligible Unable to Contact) along with a termination date. Members who are disenrolled from CIS+ may be reconsidered for identification and eligibility later. If re-entering CIS+, eligibility must be reconfirmed, and member consent must be re-obtained.

To report members who were receiving services but have exited the program to a known location, Health Plans must use one of the following status codes:

- HP (CIS+ – Exited to Permanent Housing) shall be used for enrolled members who were receiving Pre-Tenancy Supports (CIS+ status code H5) or Tenancy Sustaining Services (CIS+ status code H6) who have exited the program to a known exit destination of permanent housing or a long-term institutional setting (e.g. nursing homes).
- HT (CIS+ – Exited to Temporary Housing) shall be used for enrolled members who were receiving Pre-Tenancy Supports (CIS+ status code H5) or Tenancy Sustaining Services (CIS+ status code H6) who have exited the program to a known exit destination of temporary housing (e.g. transitional housing, homeless shelter and emergency shelter) or short-term institutional settings (e.g. hospital, short-term rehab).
- HH (CIS+ – Exited Back to Homelessness) shall be used for enrolled members who were receiving Pre-Tenancy Supports (CIS+ status code H5) or Tenancy Sustaining Services (CIS+ status code H6) who have exited the program back to homelessness (e.g. places not meant for habitation).
- HM (CIS+ – Exited Other/Miscellaneous) shall be used for enrolled members who were receiving Pre-Tenancy Supports (CIS+ status code H5) or Tenancy Sustaining Services (CIS+ status code H6) who have exited the program due to all other reasons not defined above (e.g. death, incarceration, loss of Medicaid coverage).

Notice of Adverse Benefit Determination

Notice of Adverse (NOA) Benefit Determination shall be issued to a member when the member is disenrolled from CIS+ or if the Health Plan concludes that the member does not meet eligibility criteria for benefits within CIS+. The NOA must include a complete list of the benefits available under CIS+. It must also indicate which CIS+ benefits the Health Plan assessed the member for and provide the outcome of the eligibility determination. This outcome should specify both the benefits the member is eligible for and the benefits the member is not eligible

for.

If a re-evaluation is requested as a component of an appeal, the same CIS+ assessment tools previously used to evaluate the member in the initial assessment shall be used to conduct the CIS+ eligibility reassessment. The process for such an appeal must comply with the requirements in 42 C.F.R. Subpart F for an adverse benefit determination. The Health Plan shall incorporate a protocol for how CIS+ appeals by providers and members shall be reviewed and addressed into its overall member and provider grievance and appeals processes. The NOA shall be mailed to the member and the CIS+ Provider by the Health Plan, or hand-delivered to the member when possible.

Housing Navigation Reporting Reference

Notice of Adverse (NOA) Benefit Determination shall be issued to a member when the member is disenrolled from CIS (moves to Status code H7 (CIS – Enrolled Lost to Follow Up) or if the Health Plan concludes that the member does not meet initial eligibility criteria for CIS (Status code H3 (CIS – Not Eligible)). NOAs for Status codes H7 shall indicate that the CIS disenrollment effective date will be the first of the following month. NOAs for Status code H3 (CIS – Not Eligible) and Status code H7 must provide information on the right to appeal the determination of ineligibility.

Opt-Out

Members enrolled in CIS+ will have the option to opt-out of the CIS+ program at any time. This opt-out option shall only be initiated by the member. Members may inform the CIS+ Provider or the Health Plan when exercising the opt-out option. Members may opt out of some CIS+ benefits, for example, a member can opt out of Medical Respite and continue to receive Housing Navigation.

Members who opt out and are disenrolled from the CIS+ program shall have the option to re-enroll after the member is reassessed and is determined to be eligible for the CIS+ program. The Health Plan shall continue to assist members who opt out of the CIS+ program with existing non-CIS+ wrap around services, including moving to an HCBS home as appropriate.

Re-Enrollment

Nothing shall prevent a currently enrolled Medicaid member who was formerly enrolled in the CIS+ program from enrolling again in the CIS+ program if the member meets eligibility criteria.

Reporting Reference

Health Plans must use status code H4 (CIS+ – Eligible Refused) for eligible members who refused to participate in the program at time of consent. Members who choose to re-enroll will be required to confirm eligibility and consent at that time.

Special Considerations

29. Special Considerations for CCS Members

Housing Navigation Reporting Reference

Since member identification and referral for CIS+ may occur from multiple external sources, and to encourage a 'no wrong door' policy for external referrals, such referrals shall be processed through completion of the engagement services and confirmation of eligibility by the QI Health Plan that receives the external referral; in other words, the member shall be transitioned from a status code of H1 to a status code of H2 (CIS+ – Confirmed Eligible), H3 (CIS+ – Not Eligible), or H4 (CIS+ – Contacted – Eligible Refused). This would include responding to the referring entity, and for following up if there is incomplete information. The QI Health Plan shall be responsible for completing engagement services and obtaining consent before transitioning the member to the CCS Plan.

For members receiving Housing Navigation, the QI Health Plan will change the member status code to HC prior to transitioning the member to CCS. Upon transition, the CCS Plan will complete the member assessment process and assign the status code. If the QI Health Plan is unable to reach a potentially eligible member [i.e., status code H8 (CIS+ – Potentially Eligible Unable to Contact)], the QI Health Plan shall transition the information available on the member to the CCS Plan so that the CCS Plan is well-poised to re-attempt to contact the member in the future. If a member is already receiving CIS+ services when they are newly enrolled in CCS, the QI Health Plan shall forward all information on these members to the CCS Plan and the CCS Plan should assume CIS+ services beginning with the status code that the member is in. All subsequent CIS+ requirements shall be the responsibility of the CCS Health Plan. All transitions of CIS+ members from the QI Health Plan to the CCS Health Plan shall include 'warm hand-offs.'

Health Plans shall follow existing transition of care protocols in their contract when a CIS+ member moves into or out of CCS or moves from one QI Health Plan to another. CIS+ status code appears on the 834 daily file on the 2700 loop, elements N1 through DTP03. When members are enrolled in QI and CCS, the most current CIS+ information will be available to both plans to facilitate transitions. The CIS+ status code shall only be updated when the member transitions to a new CIS+ status code under the CCS Plan's care. Please refer to additional guidance in memo QI-2003B ~~(2019)~~ on status code submission.

30. Special Considerations for Referrals from Hospitals

For hospital-based referrals, the timeframe for the Health Plan to confirm eligibility criteria, conduct an engagement visit, and to obtain consent is necessarily compressed. As such, the Health Plans need to visit the facility before the member leaves or arrange for an entity onsite to meet the member.

Health Plans shall work closely with hospital staff on proactive identification of members

potentially eligible for CIS+ as well as early notification of an admission for members potentially eligible for CIS+ and are encouraged to utilize existing electronic notification protocols to assist with the referral process. Health Plan staff shall screen the member to assess eligibility, obtain consent, organize appropriate follow up with the member, and engage a CIS+ Provider as appropriate.

Housing Navigation Reporting Reference

Upon determining the member is eligible for CIS+, obtaining consent for CIS+, and completing a member assessment, the Health Plan shall submit a status code of H5 (CIS+ – Pre-Tenancy Supports), H6 (CIS+ – Tenancy Sustaining Services) to MQD.

CIS+ Timeframes and Status Codes

31. CIS+ Activity Timeframes

Table 8 shows the maximum allowable timeframes for CIS+ activities related to Housing Navigation and Medical Respite. It also includes an example to illustrate Housing Navigation deadlines.

Table 8: CIS+ Activity Timeframe

CIS+ Activity	Housing Navigation		Medical Respite Timeframe
	Timeframe	Example Using Maximum Allowed Times:	
Internal Potential Eligible and New External Referrals	Up to 30 days to determine eligibility and authorize initial engagement and Pre-Tenancy Supports/Tenancy Sustaining Services. Encourage < 15 days to minimize service delay.	January 1, 2023: At-risk individual referred to the Health Plan by family member. January 31, 2023: Confirmed eligibility and pre-authorization for initial Engagement and Pre-Tenancy Supports/Tenancy Sustaining Supports completed.	The Health Plan shall determine eligibility within 7 days of receipt of the Medical Respite Authorization Form. If the member is being discharged from an institution in less than 7 days, the Health Plan must determine eligibility before discharge.

CIS+ Activity	Housing Navigation		Medical Respite Timeframe
	Timeframe	Example Using Maximum Allowed Times:	
CIS+ Member Consent	Encourage to obtain consent within 10 days after engagement authorized or initiated by the Health Plan (May be extended based on member need).	February 10, 2023: Consent obtained.	Health Plans must obtain consent within 10 days after eligibility is determined, or as soon as possible if the member is institutionalized or has an upcoming procedure.
PCSP	45 days from the start of the month in which the CIS+ Provider begins billing for Housing Navigation to complete the CIS+ Assessment and CIS+ Action Plan.	March 27, 2023: CIS+ Assessment and CIS+ Action Plan completed.	A PCSP must be established within 3 calendar days of Medical Respite admission, or of Health Plan authorization for members admitted before authorization.
	Submit all completed documents to the Health Plan within 30 days of completion.	April 26, 2023: CIS+ Assessment and CIS+ Action Plan submitted to the Health Plan.	
CIS+/Medical Respite Report	Submit complete CIS+ Assessment and CIS+ Action Plan data within 30 days of submission of documents to the Health Plan .	May 26, 2023: CIS+ Assessment and CIS+ Action Plan data are available to submit in the next quarterly report.	Submit complete PCSP and Medical Respite Provider Discharge Form information during the quarterly report.
CIS+ Action Plan Update	CIS+ Action Plan to be reviewed and/or updated every 90 days.	June 27, 2023: CIS+ Action Plan update due.	Not applicable.

32. CIS+ Status Codes

Health Plans must provide daily updates on members' CIS+ Status Codes, described in Table 9. For more detail on CIS+ Status Codes and the submission process, see memo QI-2003B.

Table 9: CIS+ Status Codes

CIS+ Status Code	Description	Notes
H1	CIS+ – POTENTIALLY ELIGIBLE	Use this code for potentially eligible members who have been identified based on ICD codes or other evidence and engagement IS NOT authorized.
HA	CIS+ – POTENTIALLY ELIGIBLE WITH ENGAGEMENT AUTHORIZED	Use this code for potentially eligible members who have been identified based on ICD codes or other evidence and engagement IS authorized for Housing Navigation.
H2	CIS+ – CONFIRMED ELIGIBLE FOR HOUSING NAVIGATION ~~SUPPORTS~~	Use this code for members eligible for Housing Navigation, not yet consented to participate in services.
H3	CIS+ – NOT ELIGIBLE FOR HOUSING NAVIGATION	Use this code for members who do not meet requirements for Housing Navigation.
HC	CIS+ – ELIGIBLE CONSENTED	Use this code for eligible members, who have signed a consent to participate in the CIS+ program overall. The member is considered enrolled at this time.
H4	CIS+ – ELIGIBLE REFUSED	Use this code for eligible members, who refused to participate in the program.
H5	CIS+ – PRE-TENANCY SUPPORTS	Use this code for enrolled members receiving CIS+ Pre-Tenancy Supports.
H6	CIS+ – TENANCY SUSTAINING SERVICES	Use this code for enrolled members receiving CIS+ Tenancy Sustaining Services.
H7	CIS+ – ENROLLED LOST TO FOLLOW UP	Use this code for enrolled members who have been lost to follow up with 3 or more unsuccessful attempts by the Health Plan in the past 3 months.
H8	CIS+ – POTENTIALLY ELIGIBLE UNABLE TO CONTACT	Use this code for potentially eligible members (found eligible by Health Plan) who have been unable to contact with 3 or more unsuccessful attempts by the Health Plan in the past 6 months.
HP	CIS+ – EXITED TO PERMANENT HOUSING	Use this code for enrolled members who have exited the program to a known exit destination of permanent housing or long-term institutional setting (e.g. nursing homes).
HT	CIS+ – EXITED TO TEMPORARY HOUSING	Use this code for enrolled members who have exited the program to a known exit destination of temporary housing (e.g. transitional housing, homeless shelter and emergency shelter) or short-term institutional settings (e.g. hospital, short-term rehab).

CIS+ Status Code	Description	Notes
HH	CIS+ – EXITED BACK TO HOMELESSNESS	Use this code for enrolled members who have exited the program back to homelessness. (e.g. places not meant for habitation).
HM	CIS+ – EXITED OTHER/ MISCELLANEOUS	Use this code for enrolled who have exited the program due to all other reasons not defined above. (e.g. death, incarceration, loss of Medicaid coverage).

33. Appendices

Table 10: Appendices

Appendix	Status
Appendix A – CIS+ Responsibilities	Revised from QI-2601A, CCS-2601A
Appendix B – CIS+ Referral Form	No change from QI-2601A, CCS-2601A
Appendix C – CIS+ Member Consent Form	No change from QI-2601A, CCS-2601A
Appendix D – CIS+ Assessment	No change from QI-2601A, CCS-2601A
Appendix E – CIS+ Action Plan	No change from QI-2601A, CCS-2601A
Appendix H – CIS+ Process Flow	No change from QI-2601A, CCS-2601A
Appendix I – Medical Respite Authorization Form	Revised from QI-2601A, CCS-2601A
Appendix J – Medical Respite Person Centered Service Plan	No change from QI-2601A, CCS-2601A
Appendix K – Medical Respite Provider Attestation Form	Revised from QI-2601A, CCS-2601A
Appendix L – Medical Respite Provider Discharge Form	No change from QI-2601A, CCS-2601A