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April 14, 2023

MEMORANDUM

MEMO NOS.
QI-2314
CCS-2303

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

FROM: Judy Mohr Peterson, PhD
Med-QUEST Division Administrator

SUBJECT: COMMUNITY INTEGRATION SERVICES (CIS) IMPLEMENTATION UPDATED GUIDELINES: ROLES AND RESPONSIBILITIES, FORMS, BILLING AND PAYMENT

Introduction

UPDATED GUIDANCE

This interim memo modifies CIS memo QI-2105, CCS-2102 (COMMUNITY INTEGRATION SERVICES (CIS) IMPLEMENTATION GUIDELINES: OVERVIEW, MEMBER ELIGIBILITY, SERVICE DELIVERY, COORDINATION, & REIMBURSEMENT, Released April 1, 2021).

The text of CIS memo QI-2105, CC-2102 is incorporated into this revision, identified as CIS memo QI-2314, CCS-2303. Updated guidance is inserted as shaded text. Voided text from QI-2105, CCS-2102 is stricken. **Unless specified in this memo, the implementation guidelines as stated in QI-2105, CCS-2102 are unchanged.**

Primary changes to the implementation guidelines described in this memo reflect revisions related to: Referral and Consent Forms, and Billing and Payment. The CIS Process flow has also been added as an appendix for reference.

This revised memo incorporates health plan and provider feedback regarding the CIS program. It is anticipated that the revisions facilitate member access to CIS and lessen the administrative burdens related to the program's implementation.

Additional guidance addressing other CIS documents (CIS Assessment/Reassessment, CIS Health Action Plan Addendum), reporting and sources of funding for housing services will follow in a future memo.

The Health Plan shall update and implement its CIS program per the following timelines:

- By July 1, 2023, for claims processing changes related to service dates starting May 1, 2023
- By October 1, 2023, for changes related to forms

Supportive Housing is an evidence-based practice[1] that combines affordable housing with supportive services that help eligible individuals access housing resources and remain successfully housed.

Community Integration Services (CIS)-Supportive Housing Services are the Medicaid reimbursable supportive services available to eligible QI members, that when paired with affordable housing,[2] are a cost-effective way to engage members experiencing homelessness, help reduce homelessness and increase housing stability. CIS funds supportive housing services including pre-tenancy and tenancy support services intended to help members attain and maintain safe affordable housing; CIS does not cover most housing expenses. Most importantly, CIS seeks to engage the member in self-care and personal management by establishing a personalized housing support plan that is holistic and reflective of his or her preferences and goals. CIS assists eligible QUEST Integration (QI) members with becoming fully integrated members of the community as well as achieving improved health outcomes and life satisfaction. The list of CMS approved CIS benefits are included in Appendix A.

The Community Care Services (CCS) behavioral health plan is responsible for providing CIS for CCS members. All other QI members will receive CIS through their QI health plan.

[1] The U.S. Department of Substance Abuse and Mental Health Services Administration (SAMHSA) recognizes supportive housing as an evidence-based practice and has developed toolkits for program fidelity that can be found here: https://store.samhsa.gov/product/Permanent-Supportive-Housing-Evidence-Based-Practices-EBP-KIT/SMA10-4509

[2] The U.S. Department of Housing and Urban Development (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." Taken from the HUD Glossary of Community Planning and Development Term. https://www.hud.gov/program_offices/comm_planning/library/glossary/a

Eligibility Criteria

Any QI eligible member who is homeless or is at risk of becoming homeless can be referred to the member's QI health plan to receive a CIS screening. There are no restrictions on who can make the referral. The 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.

CIS benefit eligibility criteria include being age **18 years or older** and:

1. **Member meets at least one of the following health needs-based criteria** and is expected to benefit from CIS:
    a. Individual assessed to have a behavioral health need which is defined as one or both of the following criteria:
        i. 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
        ii. 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 a Substance Use Disorder (SUD)

    OR

    b. 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).

AND

2. **Member has at least one of the following risk factors:**
    a. Homelessness, defined as lacking a fixed, regular, and adequate nighttime residence, meaning:
        i. Has a primary nighttime 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; or
        ii. 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

b. At risk of homelessness, defined as an individual who will lose their primary nighttime residence:
   i. There is notification in writing that their residence will be lost within 21 days of the date of application for assistance;
   ii. No subsequent residence has been identified; and
   iii. Does not have enough resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to or living in a place not meant for human habitation, a safe haven, or an emergency shelter; or
   iv. History of frequent and/or lengthy stays in an institution.
      1. Frequent is defined as more than one contact in the past 12 months.
      2. Lengthy is defined as 60 or more consecutive days within an institutional care facility.

QI Health Plan Roles and Responsibilities

~~The Health Plan shall develop and implement its CIS program, per guidance specified below, no later than July 1, 2021.~~

UPDATED GUIDANCE

The health plan is responsible for the implementation of the CIS program and for determining and authorizing the specified services that are necessary and appropriate for beneficiaries. If authorized by the health plan, the provider has primary responsibility for outreach and for the delivery of pre-tenancy and tenancy support services. MQD expects that a team-based approach is applied to all aspects of program implementation and in managing members' needs.

The Health Plan may contract with provider agencies to perform CIS services, including CIS member assessments and reassessments and CIS Health Action Plan Addendum development.

1. **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. QI Entry points into CIS include:

   a. QI 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. QI health plan analyses of utilization data on members who are identified to be homeless or potentially homeless to establish health needs-based criteria;
   c. QI 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 the Homeless Management Information system (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 QI health plan activities;
   g. Quality improvement activities through QI health plan;
   h. HFA assessments/re-assessments for QI 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, Department of Health's (DOH) Alcohol and Drug Abuse Division (ADAD) and Adult Mental Health Division (AMHD);
   k. 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;
   l. Referrals from MQD Medicaid eligibility workers, and other MQD staff;
   m. Re-entry worker/system referrals for example from the Hawaii State Hospital (HSH), prisons, drug treatment facilities, etc.; and
   n. Members, or their friends and family members.

2. **CIS Referral and Eligibility Confirmation**

   ~~The **CIS Referral Form** is provided in Appendix B.~~

UPDATED GUIDANCE

A shortened, revised 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 CIS Referral Form to be completed, QI Health plans must make arrangements to electronically capture the referral/identification source on all CIS beneficiaries, as these data shall be included among required reporting elements.

CIS referral forms shall be sent to the member's QI health plan or to MQD/HCSB if member's QI health plan is unknown. MQD will forward any CIS referral forms received to the member's current QI health plan. Referrals should be as complete as feasible before submission to the QI health plan; 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 QI health plan's responsibility to obtain and assure completeness of information and documentation to confirm eligibility for CIS.

Upon referral notification, the QI health plan will independently verify that the member meets eligibility criteria. *If the member is identified to be in immediate danger, or is currently a threat to self or others, the QI health plan shall take immediate action to provide resources to stabilize the members, regardless of eligibility for CIS.*

For any new external referrals received, the QI health plan shall have 15 days from the receipt of the referral to review documentation, obtain any missing information either from the referring party or from other sources, make a determination as to whether the member meets or fails to meet eligibility criteria for CIS, and provide its decision to the referring party.

The QI health plan is referred to diagnosis criteria for CCS for a presumptive definition of Serious Mental Illness (SMI); however, the QI health plan shall use discretion to potentially confirm eligibility of members who do not strictly meet CCS diagnostic criteria, but still may be classified as having SMI. If the QI health plan concludes that the member does not meet eligibility criteria for CIS, the referring party must be provided information on how to appeal the decision. The QI 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.

In addition to receiving referrals, as noted earlier, Health plans are expected to identify potentially eligible CIS beneficiaries through the new member welcome calls/surveys, as

well as through data analytics at least once per quarter. Data analytics includes QI members who were previously at any stage of CIS, and eventually disenrolled from the program (especially when disenrolled due to lack of contact); therefore, if any of these members are re-identified to continue to be eligible for CIS, they shall be re-assigned a status code of H1 (CIS – Potentially Eligible Additionally, referrals from other QI health plan staff are expected to be received and evaluated on an ongoing basis. New members identified as potentially eligible for CIS through any internal source, including QI health plan analytics, shall be deemed to be eligible or ineligible for CIS within 30 days upon receipt of the referral.

The QI health plan shall develop a plan to process and clear the backlog of any existing referrals in its systems at the start of implementation, including prioritizing members with more complex physical or behavioral health needs using a risk-based algorithm or other predictive analytics tool. The QI health plan's backlog and plan, including timeline, for clearing any backlogs of existing referrals, shall be described as part of CIS reporting requirements, which shall be outlined in a subsequent memorandum that MQD shall release.

Members are considered to be in status H1 (CIS – Potentially Eligible) when they have been referred or otherwise identified through any method as being potentially eligible for CIS services. 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).

3. **CIS Member Consent**

~~The **CIS Member Consent Form** is provided in Appendix C. Once a member is deemed eligible for CIS, the QI health plan shall contact the member and obtain consent to participate in the program. In the consent form, an appropriate CIS outreach coordinator, either from the QI health plan or CIS provider, shall confirm the eligibility criteria and obtain current member demographics that support service delivery.~~

UPDATED GUIDANCE

The shortened, revised CIS Member Consent Form is provided in Appendix C.
Once a member is deemed eligible for CIS, the QI health plan or CIS provider shall contact the member and obtain consent to participate in the program.

CIS eligibility must be determined by the Health Plan prior to obtaining member consent to participate in CIS. For external referrals, the Health Plan may obtain CIS consent. In all other cases, a CIS provider shall be prior authorized to complete the consent process.

~~As part of the consent process, the CIS outreach coordinator 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.~~ ~~*If during the consent process, the member is identified to be in immediate danger, or is currently a threat to self or others, the QI health plan shall take immediate action to provide resources to stabilize the members, regardless of the member's consent to participate in CIS.*~~

UPDATED GUIDANCE

As part of the consent process, the Health Plan or 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.

Execution of the consent form shall transition a member's CIS status from H2 (CIS – Contacted – Confirmed Eligible) to H5 (CIS – Housing Pre-Tenancy). The QI health plan or CIS provider shall have ten (10) business days after the QI member moves into H2 (CIS – Contacted – Confirmed Eligible) to locate and meet with QI member to obtain consent for CIS. Members who refuse to provide consent to participating in CIS shall be transitioned to a CIS status of H4 (CIS – Contacted – Eligible Refused). The QI health plan shall electronically capture all information on the consent form for reporting to MQD.

UPDATED GUIDANCE

Post-Consent Transition Period:

MQD recognizes that there is a period of transition post-consent during which the member is enrolled in CIS but awaiting completion of the HFA and/or CIS Assessment, the Health Action Plan and/or CIS Housing Action Plan. To ensure continued member engagement, establish trust with the member, eliminate barriers to services and in preparation for the delivery of pre-tenancy and tenancy support services, preparatory activities which further the pursuit of stable housing may be delivered during this transition period under HCPCs code H0044.

4. **CIS Member Assessment and Re-Assessment**

The **CIS Member Assessment/Re-Assessment Tool** is provided in Appendix D. This tool is a modified version of the "Housing Case Management Assessment Tool" currently in use by the CIS provider community. The purpose of the tool is to collect systematic self-reported health 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 tool has two sections:

a. Section A: Member Self-Assessment where the assessor will administer questions to the member and note down their responses. The member, and member advocate if applicable, will sign to attest to the information provided in Section A.
b. Section B: The interviewer will conduct an independent assessment of the member. As part of Section B, the interviewer shall score the member's responses, and independently assess and score member acuity. Both scores (Member Assessment Acuity Score and Interviewer Assessed Acuity Score) shall be used to prioritize members for tenancy services.

The same tool shall be used for initial assessment and subsequent reassessments. ~~The health plan or CIS provider shall have fifteen (15) days after the date of consent to assess members newly enrolled in CIS; MQD encourages but does not require health plans/CIS providers to complete the assessment immediately upon completion of the consent process.~~

UPDATED GUIDANCE

The health plan or CIS provider shall have thirty (30) days after the date of consent to assess members newly enrolled in CIS; MQD encourages but does not require health plans/CIS providers to complete the assessment immediately upon completion of the consent process.

The assessment/re-assessment will be completed by a CIS Provider and submitted to the health plan. A re-assessment shall be conducted every three (3) months.

Health plans shall be required to submit data collected in both sections of the CIS Member Assessment Tool as part of reporting requirements. Therefore, the tool provided in Appendix D may be operationalized as health plans see fit to ensure data collection that enables reporting to MQD.

If during the assessment or reassessment 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.

5. **Other CIS-Related Assessments**

Some community providers may also complete the Vulnerability Index-Service Prioritization Decision Assistance Tool or VI-SPDAT. This assessment should be included in the CIS member assessment process for members eligible for the Homeless Management Information System (HMIS) and Coordinated Entry Services (CES).

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

6. **CIS Health Action Plan Addendum**

The **CIS Health Action Plan Addendum** shall capture the services needed and plan for provision of these services to the member. The CIS Health Action Plan Addendum is provided in Appendix E. The CIS Health Action Plan Addendum may be used as a stand-alone document to plan CIS services for members who do not need additional Health Coordination Services.

For members newly enrolled in CIS, the health plan or CIS provider shall have a total of thirty (30) days from the completion of the initial member assessment to complete the CIS Health Action Plan Addendum. The plan must be reviewed with, agreed to, and signed by the member and preparer before it is considered final. The CIS Health Action Plan Addendum shall be reviewed and updated every three (3) months.

Planning shall be a person-centered process, and the results of the assessment/re-assessment shall guide the development of the CIS Health Action Plan Addendum. CIS service planning shall be conducted with the member and shall develop plans to provide the CIS services and supports corresponding to needs identified in the assessment/re-assessment in the following categories:

a. Housing supports, including completion of any housing assessments needed for housing placement
b. Medical supports
c. QUEST and other DOH program supports
d. Safety supports
e. Social Determinants of Health-based supports

f. Financial assistance and/or supports
g. Employment and housing readiness supports
h. Any other supports not identified/categorized elsewhere

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 current contact information and non-submission of required documentation. As a result, the CIS Health Action Plan Addendum 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 Health Action Plan Addendum 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; 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: In addition to the CIS Health Action Plan Addendum, the health plan shall also create crisis plans and eviction prevention plans with members enrolled in CIS. MQD encourages health plans to work together to develop a standard approach for crisis and eviction prevention planning that include:

a. Behaviors or situations that may threaten housing or health, based on past experiences.
b. Actions the member-tenant will take to prevent or avert a crisis or eviction.

Crisis plans must be completed for all CIS members. Eviction prevention plans shall be in place for members in tenancy status (CIS status code H6 (Beneficiaries in Tenancy)).

~~7.~~ **~~CIS Packet~~**

UPDATED GUIDANCE

7. Forms and Reporting

Health plans and providers shall use the following forms to collect data.
CIS members who accept health coordination must have a Health and Functional Assessment (HFA) and Health Action Plan (HAP) completed.

The CIS Assessment/Reassessment may be used as a stand-alone document to identify the CIS needs of members who opt out of Health Coordination Services.

Table 1. CIS Forms

Form	Version	Location	Future Action
Referral Form (optional)	Revised	See QI-2314 Appendix B	N/A
CIS Consent Form	Revised	See QI-2314 Appendix C	N/A
Health and Functional Assessment (HFA) & Health Action Plan (HAP) (if applicable)	Unchanged	Unchanged	Form being updated
CIS Assessment/Reassessment	Unchanged, continue to use this form	See QI-2105, Appendix D	Form being updated, to be issued in future memo
CIS Health Action Plan Addendum	Unchanged, continue to use this form	See QI-2105, Appendix E	Form being updated, to be issued in future memo

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

There are no changes to the reporting guidelines and reporting format described in QI-2105. A subsequent memo will provide additional guidance regarding forms, reporting guidelines and reporting format. Providers should continue to collect data required by their respective health plan contracts in anticipation of audit and/or reporting requirements.

The "CIS Packet" shall comprise the CIS Consent Form, CIS Assessment/ Reassessment, any other CIS-related assessments completed on the member, CIS Health Action Plan Addendum, crisis plan, and eviction prevention plan (as applicable). The CIS Packet shall be submitted by the CIS provider directly to member's health plan. A copy of the CIS Packet shall be maintained by the health plan. The CIS provider shall also maintain a copy and make a copy available to the member for review upon request. Additionally, the CIS Packet shall be shared with the member's Primary Care Provider and care team (if applicable). If the member is in CCS, the packet shall also be shared with the member's QI health plan. CIS Packet items (specifically, the member re-assessment and CIS Health Action Plan Addendum) shall be reviewed and updated with CIS members every three (3) months, at a minimum.

The CIS Referral Form and the individual forms that make up the CIS packet shall be completed within the various maximum timeframes as detailed in section 2 through section

6 above. MQD encourages health plans to take steps to have these various forms completed sooner than the stated maximums. To that end, and where possible, health plans are encouraged to have multiple forms completed during a single member visit.

~~Pre-tenancy and tenancy sustaining services to be provided are based on the member's CIS Health Action Plan Addendum and may not be provided or billed prior to receipt of an authorization for service.~~ Information on services and supports authorized via the CIS Health Action Plan Addendum as well as progress on the provision of these services shall be captured electronically by the health plan and submitted to MQD as part of reporting requirements.

~~8. **Prior Authorization for CIS Pre-Tenancy and Tenancy Services**~~

UPDATED GUIDANCE

8. Authorization, Billing and Payment

Prior authorization from health plan is required before services are provided or billed by the provider. Prior authorization turnaround times shall align with standard utilization management turnaround times of 14 days for routine request and 72 hours for urgent requests.

Providers must bill the health plan (or the CCS health plan if the member is a CCS member) that the member is enrolled in as of the last date of monthly service. Submission of clean claim to health plan shall result in a per-member-per-month (PMPM) bundled payment to provider. Provider is limited to one monthly bundled payment per member for either the outreach services category or the supports (pre-tenancy/tenancy) services category. Claims payment shall align with standard claims payment timeframes. Health plan 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 auditing of provider documentation as part of provider oversight activities.

Health plans will submit daily CIS member files to update MQD on CIS status code changes (reference memo QI-2003).

Monthly Outreach Services

Health plans will authorize PMPM CIS outreach, screening and/or eligibility activities in a minimum of one (1)-month increments. It is generally expected outreach will not extend beyond 3 months, however, it remains at the discretion of health plan to determine appropriate duration. Provider's outreach services may be billed to 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 Supports (Pre-Tenancy/Tenancy) Services

Health plans will authorize PMPM CIS supports (pre-tenancy and tenancy) services in three (3)-month increments. After the CIS consent form is completed, monthly supports services may be billed to health plan using HCPCS code H0044 for pre-tenancy and tenancy services listed in Appendix A. 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 health plan changes CIS providers, health plan shall support the transition of care.

Table 2 contains HCPCS codes used for billing and encounter data submission purposes, along with MQD's proposed rates of reimbursement, are provided below.

Table 2. Monthly CIS Service Categories

Service Category	Service Description	HCPCS Code	Proposed Rate
CIS Outreach			
Outreach (pre-consent)	• Outreach • Obtain member CIS consent or refusal	**T1023**	QI: One bundled payment $200 per member per month CCS: One bundled payment $50 per member per month
CIS Support (after CIS consent form is completed)			
Support (post-consent)	• Transition, collaboration, and documentation • CIS Assessment/Reassessment • CIS Health Action Plan Addendum • Pre-tenancy supports • Tenancy sustaining services	**H0044**	QI & CCS: One bundled payment $350 per member per month

Claims submitted by CIS provider shall include the appropriate Place of Service (POS) codes to indicate setting and differentiate face to face and non-face to face services. Examples include POS 04 (homeless shelter), POS 14 (group home), POS 16 (temporary lodging) or POS 15 (mobile unit). Services rendered via telehealth shall be billed as outlined in memorandum QI-2139.

Payment for other housing or housing-related supports that fall outside of those listed in Appendix A is not allowed as a CIS/Medicaid benefit. See Appendix F for a list of homeless programs funded & CIS funded services.

Outreach and other CIS services rendered by CIS providers for non-Medicaid members shall not be paid by Health plans but shall be paid by appropriate DHS/BESSD/Homeless Program Office (HPO) grant monies. The health plan shall pay for any services that may be authorized for eligible CIS members. The provider shall only bill health plans for approved CIS services rendered to Medicaid members. The provider shall bill HPO for CIS services rendered to non-Medicaid members as well as non-CIS housing-related services rendered to Medicaid members. See Appendix F for a list of HPO funded & CIS funded services.

~~Health plans will review and approve the CIS Packet, then authorize CIS pre-tenancy and tenancy services as necessary in three (3)-month increments. The health plan is responsible for ensuring that rules of conflict-free case management are followed and that CIS service providers for the individual must not also provide case management or develop the CIS Health Action Plan Addendum for the same individual. When the health plan assigns a CIS provider to obtain consent, geography, participant preference and alignment with participant needs shall be considered.~~ ~~Prior authorization turnaround times shall align with standard utilization management turnaround times of 14 days for routine request and 72 hours for urgent requests~~. ~~Health plans shall develop templates for utilization management reviews that will be shared with MQD and CIS Providers. Health plans are encouraged to work together to collaboratively develop these templates and develop similar processes between plans for ease of development for the health plans and to minimize provider abrasion on the CIS provider network.~~

~~The health plan and CIS provider shall work together to coordinate and link the member to QI benefits and providers including needed primary care, health homes and home and community-based services; substance use treatment providers; mental health providers; medical, vision, nutrition and dental providers; crisis services; end of life planning; and needed Medicaid eligibility assistance. The health plan shall subcontract/delegate services to CIS providers to the greatest extent possible. CIS provider shall coordinate and link the member to education, vocational rehab, employment and volunteer supports; other support groups and natural supports; food stamps; financial supports and legal services as needed. 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. The health plan may decide to change CIS providers as needed if doing so would be in the best interest of the CIS member. Any time there is a change in the CIS provider for a given member, the health plan shall support the transition of care through warm hand-offs.~~

9. **Billing and Payment**

Health plans shall authorize CIS providers to render services and receive payment for three types of CIS services:

a. Outreach Services

Outreach services may be billed for services related to locating the member and conducting any additional screening services to determine program eligibility, and completing the consent process, including refusal to consent into the program. When the health plan or the CIS provider is unable to find the member, the health plan shall engage in assertive outreach services to locate and engage the member to accept CIS services. Completion of all activities tied to outreach will result in a single bundled payment. Completion of outreach activities should also reflect progress on the member's CIS status code. As outreach activities occur, member status code should transition from H2 (CIS – Contacted – Confirmed Eligible) to H4 (CIS – Contacted – Eligible Refused), H5 (CIS – Housing Pre-Tenancy), H6 (CIS – Housing Tenancy) or H8 (CIS – Unable to Contact), with movement to H5 the most likely route for a CIS member that has consented and is about to begin pre-tenancy services. Outreach services may only be billed to the health plan that the member is enrolled in at the completion of outreach activities. Since members who were previously in CIS but were unable to be contacted (i.e., status codes H7 and H8) may be disenrolled from the program and re-identified as potentially eligible for CIS (i.e., status code H1) through analytics, they would become eligible for Outreach Services once again.

b. Completion of the CIS Packet

The CIS Packet requirements are described in detail above. The provider completing the CIS Packet shall bill the health plan upon submittal of the CIS Packet documentation to the health plan. Payment shall be made by the health plan to the provider in the form of a single bundled payment. The bill must be sent to the health plan that the member is enrolled on the billing date, or to the CCS health plan if the member is a CCS member. This bundled payment shall only be made to CIS members who have transitioned to a status code of H5 (CIS – Housing – Pre-Tenancy) or H6 (CIS – Housing – Tenancy) from a status code of H2 (CIS – Contacted – Confirmed Eligible). A bundled payment for subsequent re-assessments and plan update services will not be paid for by health plans. In instances where the CIS member previously in H5 (CIS – Housing – Pre-Tenancy) or H6 (CIS – Housing – Tenancy) statuses transitioned to a status code of H7 (CIS – Beneficiary lost to follow up) and then was re-confirmed to be eligible for CIS, re-assessments and plan updates for CIS members in H5 (CIS – Housing – Pre-

~~Tenancy) or H6 (CIS – Housing – Tenancy) statuses shall be considered a part of the CIS monthly benefit.~~

~~c. CIS Monthly Benefit~~

~~CIS-specific housing supports provided shall encompass the list of CMS approved CIS benefits as previously described in Appendix A. However, as part of the CIS Health Action Plan Addendum, the health plan may also pay for all other non-housing services and supports that are available to qualifying members. Payment for any other housing or housing-related supports that fall outside of those listed in Appendix A is not allowed as a CIS/Medicaid benefit. See Appendix F for a list of homeless programs funded & CIS funded services.~~

~~Health plans should use a standard PMPM payment approach to pay for CIS pre-tenancy and tenancy services for CIS members in status H5 (CIS – Housing – Pre-Tenancy) or H6 (CIS – Housing – Tenancy). Service providers must submit a monthly claim containing a CIS-specific supportive housing procedure code. This claim should also contain all applicable encounter tracking codes for services rendered during a given month, along with dates each service was rendered.~~

~~In order to qualify for the full monthly payment, the member shall be in a H5 (CIS – Housing – Pre-Tenancy) or H6 (CIS – Housing – Tenancy) status on the first day of the month. Health plans may pay a payment prorated on a daily basis for members in H5 or H6 status for part of the month. In instances where more than one service provider has rendered pre-tenancy or tenancy services in a single month, health plans are authorized to prorate the PMPM payment to more than one service provider proportional to the total hours of CIS work rendered.~~

~~In order to receive the CIS monthly payment, CIS providers are required to have documented at least 240 minutes of service (of which 75% must be face-to-face) on a monthly basis to receive the monthly capitation payment. The health plans may make exceptions to these requirements on a case-by-case basis, but MQD prefers face-to-face interaction for CIS members. Codes to capture minutes of services rendered to a member are provided in this memo. There should be a minimum of weekly visits for the first three (3) weeks when the member first enters pre-tenancy and after the member moves into housing to assist with immediate barriers and other high priority adjustment issues. Additionally, there must be documentation of the provision of at least one encounter tracking code for services rendered during the month. The specific encounter tracking codes for services rendered must align with the services the health plan has authorized for the member. In addition, health plans shall require reporting of housing~~

~~status code changes from H5 (CIS – Housing – Pre-Tenancy) to H6 (CIS – Housing – Tenancy) (or vice versa) and/or H7 (CIS – Beneficiary Lost to Follow Up) by CIS providers.~~

The health plan shall collect more detailed data to track the CIS Provider's progress on completing or providing the member-specific services and support needs identified in the CIS Health Action Plan Addendums part of quarterly reassessments. This data shall be reportable to MQD as part of reporting requirements. ~~Health plans will additionally submit a daily CIS member files to update MQD on CIS status code changes, as described further in memo QI-2003. Minimum requirements for a PMPM payment are preliminary and discussions around potential adjustments to this policy will occur between MQD, health plans and CIS provider agencies. Health Plans are encouraged to collaborate to develop streamlined billing guidelines (e.g., forms and formats for submission) and reporting requirements for homeless service providers.~~

~~d. Miscellaneous Payments~~

~~In addition to the standard PMPM approach, MQD recognizes that there may be instances where some Fee-For-Service (FFS) options for payment may be necessary; as one key example, a member who was previously in pre-tenancy who misses appointments may require multiple follow-up actions, and after several unsuccessful attempts may become lost to follow up (CIS status code H7 (CIS – Beneficiary lost to follow up). To encourage follow-up actions to locate and re-engage the member, MQD offers a FFS payment option at a proposed reimbursement rate that is relatively comparable to other activities in the program. The health plan is encouraged to use the FFS payment option judiciously to compensate for miscellaneous activities that occur outside of the bundled services as needed.~~

~~HCPCS codes along with appropriate modifiers and diagnostic codes used for billing and encounter data submission purposes, along with MQD's proposed rates of reimbursement, are provided below. Health plans are required to submit all encounter data to MQD including encounters pertaining to services rendered under the capitation arrangement. MQD requires that encounter data be submitted regardless of whether the CIS services were rendered by health plan employees or service providers in the community, and even if in that month the plan does not have responsibility to pay the CIS providers. This is required to enable comprehensive tracking of services provided.~~

Service Category	Service Description	HCPCS Code	Modifier	Applicable Dx Codes	Proposed Rate
		Billable Codes			
		Outreach			
	Outreach and screening to verify program eligibility and obtain member CIS consent	**T1023**	**N/A**	Z13.9	$85 one time bundled payment upon completion of eligibility verification and consent process.
		Completion of the CIS Packet			
	Assessment	**T2024**	**U1**	Z02.89[a]	$150 bundled payment for the initial assessment/plan
	Individualized plan development	**T2024**	**U2**		
		CIS Monthly Benefit			
	Supportive housing, per month	**H0044**	**-**	Z76.89	$350 PMPM

Table 3. Encounter Tracking Codes					
		Pre-Tenancy & Tenancy Supports			
Service Category	**Service Description**	**HCPCS Code**	**Modifier**	**Applicable Dx Codes**	**Proposed Rate**
	Provision of housing supports	**H0043**	**U3**		N/A
	Provision of medical reengagement and care coordination supports	**H0043**	**U4**		N/A
	Provision of QUEST and Other DOH Program referral supports	**H0043**	**U5**		N/A
	Provision of safety supports	**H0043**	**U6**		N/A
	Provision of supports to address Social Risk Factors	**H0043**	**U7**		N/A
	Provision of Financial assistance supports	**H0043**	**U8**		N/A
	Provision of employment and	**H0043**	**U9**		N/A

	housing readiness supports				
	Provision of other supports not identified elsewhere	**H0043**	**UA**		N/A
	Re-assessment and plan revision	**H0043**	**UB**		N/A
	Other services to member	**H0043**	**UC**		N/A
	Case management, each 15 minutes *for CIS services*	**T1016**	**U1**		N/A
Actions to Support Members Lost to Follow-Up and other Miscellaneous Activities					
	Case management, each 15 minutes *for follow-up of crisis contacts and missed appointments*	**T1016**	**U2**		$21.25 per 15 minutes of follow-up activities completed

[a]Additional codes to indicate applicable socioeconomic and psychosocial circumstances (Z55-Z65), including but not limited to homelessness, should also be provided on the claim.

Claims submitted by CIS provider shall include the appropriate Place of Service (POS) codes to indicate setting, and differentiate face to face and non-face to face services. CIS services may be rendered via telehealth as appropriate, as long as the required face-to-face interaction requirements are met (See Section 16, Service Settings for more information). Services rendered via telehealth shall be billed with the additional and appropriate telehealth modifiers, and applicable POS codes, as outline in memorandum QI-1702A.

Outreach and other CIS services rendered by CIS providers on non-Medicaid members shall not be paid by Health plans but shall be paid by appropriate DHS/BESSD/Homeless Program Office (HPO) grant monies. The health plan shall pay for any services that may be authorized for eligible CIS members; in other words, if CIS can cover a service, then the health plan shall pay for that service. In these cases, the provider shall only bill health plans for approved CIS services rendered to Medicaid members, and shall continue to bill HPO for CIS services rendered to non-Medicaid members as well as non-CIS housing-related services rendered to Medicaid members. See Appendix F for a list of HPO funded & CIS funded services.

10. 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 Billing and Payments 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 supportive housing services for Medicaid members.
- Health plans are strongly encouraged to participate in the Homeless Management Information System (HMIS).

MQD strongly encourages the health plan to establish team-based care supports to address CIS. The use of peer support specialists and community health workers as part of the team is encouraged and allowed. When utilized, the monthly benefit payments shall include services provided by all team members. ~~The health plans shall lead the planning and provision of collaborative and joint provider orientation and training sessions; MQD can support health plans as needed. These orientation and training sessions shall address the standardization of CIS billing requirements, CIS payment methodologies, CIS provider qualification standards, and Medicaid program integrity concerns around CIS.~~

UPDATED GUIDANCE

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.

11. MQD Learning Communities and Rapid Cycle Assessments

Health plans shall participate in quarterly "learning communities" with 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 be monthly or more frequently when necessary, such as during the initial rollout of CIS services. Health plans shall also participate in MQD-led quarterly 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 and Value-Based Purchasing (VBP).

UPDATED GUIDANCE

MQD will support a new Performance Improvement Project (PIP) undertaken by Health Plans that promotes collaboration between health plans and provider agencies participating in the CIS program. Additional information regarding this PIP will be shared when available.

12. <u>Qualifications of CIS Providers</u>

Contracted CIS providers must have at least one year of demonstrated experience and ability to provide services per the specifications of the contract. This includes maintaining all necessary licenses, registrations and certifications as required by law. Health plans may develop more stringent or additional credentialing requirements beyond the minimum requirements stated here.

Direct service providers must possess the appropriate qualifications. Preferred qualifications are provided below:

Table 3. Provider Qualifications	
Category	**Direct Service Provider Preferred Qualifications**
Education	Bachelor's degree in a human/social services field
Experience	1-year case management experience, or 1-year field experience with a homeless **or** transitional housing agency. Field experience may include community outreach; 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 Community Integration Services, **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.

At orientation newly hired direct service providers are required to complete training in Supportive Housing Best Practices in outreach, engagement, and providing supportive

services; common DSM V diagnoses in the CIS population and addressing them in Fair Housing; Harm Reduction principles; Housing Referrals and Coordinated Entry processes; HIPAA; and Medicaid documentation and false claiming. Additionally, providers must complete annual training in Trauma Informed Care, HIPAA, Fair Housing, and on how to report and address Major Unusual Incidents/Adverse Events.

13. <u>Program Integrity Responsibility</u>

Health Plans must ensure services paid for and covered under CIS were rendered and properly billed 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

14. <u>Documentation</u>

All contacts and activities that assist a CIS member shall be documented by the CIS provider. The CIS Provider and/or the health plan shall document all outreach attempts to engage member. The health plan shall work in collaboration with CIS providers to track the provision of services.

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 housing support plan; and
- Signature or electronic signature using credentials, as applicable.

Progress notes should follow principles of documentation generally accepted in the social work field.

15. CIS Member Rights and HCBS Rule

When the member becomes a CIS supportive housing tenant, the member's CIS-supportive housing services must be provided in a community-integrated setting selected by the member as defined in the Home and Community-Based Setting (HCBS) rules in 42 C.F.R. Sec. 441.530. Details of the HCBS Member Rights can be found in Appendix G. The CIS services provider and health plan must review any modifications to the member's rights with member as described in Appendix G at least quarterly to determine if it is still effective and needed.

16. Service Settings

CIS services shall be rendered to the member in a setting appropriate to the type of service being rendered. Pre-tenancy housing transition services 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 services are most often rendered at the member's home but may also be rendered in other community setting where pre-tenancy services 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.

17. Disenrollment and Re-Enrollment

Members may be disenrolled from the CIS program. A member disenrolls from CIS, the member's current status code must be end dated and sent to MQD by the health plan. Reason codes may be added at a later date.

Possible Disenrollment Reasons
The member:

- Requested voluntary disenrollment – option to "opt out" of the CIS program;*
- Moved into a licensed/certified HCBS home, therefore no longer meets criterion for CIS services;
- Lost Medicaid eligibility;
- 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, and the member and health plan mutually agree that CIS services are no longer needed.

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 outreach 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 – Beneficiary Lost to Follow Up) or H8 (CIS – Unable to Contact) along with a termination date. Upon disenrollment, members will no longer have an active CIS status code. Members who are disenrolled from CIS may be re-considered for identification and eligibility at a later date. If re-entering CIS, eligibility must be re-confirmed, and member consent must be re-obtained.

Notice of Adverse Benefit Determination
Notice of Adverse (NOA) Benefit Determination shall be issued to a member when member is disenrolled from CIS (moves to Status code H7 (CIS – Beneficiary Lost to Follow Up) or H8 (CIS – Unable to Contact) or if the health plan concludes that the member does not meet initial eligibility criteria for CIS (Status code H3 (CIS – Contacted – Not Eligible)). NOAs for Status codes H7 or H8 shall indicate that the CIS disenrollment effective date will be the first of the following month. NOAs for Status code H3 (CIS – Contacted – Not Eligible) must provide information on the right to appeal the determination of ineligibility. If a reassessment is requested, 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.

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. Member may inform the CIS provider or the health plan when exercising the opt-out option. 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 again enrolling again in the CIS program if the CIS Consent and Member Requirements form is signed by member and member meets eligibility criteria.

18. Special considerations for CCS Members

CCS shall be responsible for the CIS service delivery when member is enrolled in CCS. 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 Outreach Services step in Section 9.a, and member progress made up to 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 – Contacted – Confirmed Eligible), H3 (CIS – Contacted – 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 outreach services before transitioning the member to the CCS plan. It is expected that the CCS plan will complete the consent and member assessment process to transition the member into a subsequent status code (e.g., H5 or H6). If the QI health plan is unable to reach a potentially eligible member [i.e., status code H8 (CIS – Unable to Contact)], the QI health plan shall disenroll the member, but additionally 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 in CIS when they are newly enrolled in CCS, the QI health plan shall forward all information on these members to the CCS health plan and the CCS plan should assume CIS services beginning with the status code that the member is in. All subsequent CIS requirements from Section 4 forward in the memorandum forward 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-2003 (2019) on status code submission.

19. Special considerations for Referrals from Hospitals

For hospital-based referrals, the timeframe for the health plan to confirm eligibility criteria, conduct an outreach 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 or their designee shall screen the member to assess eligibility, obtain consent, organize appropriate follow up with the member, and engage a CIS provider as appropriate. The health plan staff or CIS provider will set up a time to visit the member to do the assessment. 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 – Housing – Pre-Tenancy) to MQD.

Successful enrollment into status H5 (CIS – Housing – Pre-Tenancy) when member is assessed in the hospital may bypass the status code H2 (CIS – Contacted - Confirmed Eligible); in some cases, when referral, eligibility confirmation and consent are completed on the same day, the status code of H1 (CIS – Potentially Eligible) may also be bypassed. In these cases, the health plan would not need to submit "by-passed" status codes to MQD. If the transition from one status code to another does not occur on the same day, then both status codes must be reported. Follow up includes immediate coordination of health care benefits by the Health Plan.

20. <u>Special considerations for the Queen's Care Coalition (QCC)</u>

The Queen's Care Coalition (QCC) provides coordinated care for Super Utilizer and Native Hawaiian patients at risk for readmission by connecting them to community resources such as appropriate medical care, supportive temporary or permanent housing services, social services, behavioral health, etc. with the goal to navigate patients into progressively better circumstances while reducing unnecessary hospital utilization. The pre-tenancy services provided by QCC include navigation, which includes an assessment of a member's medical condition, registration into various systems, such as but not limited to the HMIS system, completion of VI-SPDAT evaluations, and gathering of all necessary documentation required for accessing housing.

Navigation is patient-centered, and may include, but is not limited to the following:

a. Coordination of follow-up appointments
b. Connecting primary care and specialty care services
c. Education on medications
d. 30-day transitional care
e. Access to transportation
f. Accessing proper documentation
g. Access to benefits
h. Insurance access

i. Linkage to community resources including immediate shelter and then permanent housing

As such, QCC operates as a provider of pre-tenancy services and shall be considered and treated a CIS provider by the health plan. QCC shall send a referral form to the member's Health Plan for the Health Plan to screen for CIS eligibility, moving member to status code H1 (CIS – Potentially Eligible). After the Health Plan confirms eligibility, QCC may add the member's signed CIS consent to their current housing assessment *or* use the CIS consent form that includes the consent for CIS services, moving member to status code H2 (CIS – Contacted – Confirmed Eligible). The health plan may then authorize QCC to conduct the CIS assessment. Copies of the completed CIS Packet shall be sent to the Health Plan. Once received, the Health Plan shall review the CIS Packet and then move to authorize CIS Pre-Tenancy services as appropriate. The CIS pre-tenancy services provided by QCC may be billed to the member's health plan and shall be paid as Outreach Services (Section 9.a) and Completion of CIS Packet (Section 9.b). There is an expectation that QCC will coordinate a warm hand-off to a CIS provider to provide additional pre-tenancy and tenancy support services as needed to the member, and health plans shall assist in coordinating this warm hand-off. MQD encourages other hospitals and clinics to provide the same services as QCC. ~~Assessment and plan development services must follow the rules of conflict free case management.~~ QCC shall be subject to the same reporting and documentation requirements as other CIS providers.

Table 4. Appendices

Appendix	QI-2105, CCS-2102	QI-2314, CCS-2303
Appendix A-Responsibilities	Unchanged	See QI-2105, CCS-2102
Appendix B-Referral	Retired	Revised, included as Appendix B
Appendix C-Consent to Participate	Retired	Revised, included as Appendix C
Appendix D-CIS Member Assessment-Reassessment	Unchanged, form being updated, to be issued in future memo	See QI-2105, CCS-2102
Appendix E-CIS Action Plan	Unchanged, form being updated, to be issued in future memo	See QI-2105, CCS-2102
Appendix F-HPO Funding-CIS Funding	Unchanged	See QI-2105, CCS-2102
Appendix G-HCBS-Member Rights	Unchanged	See QI-2105, CCS-2102
Appendix H-Process Flow	N/A	New, included as Appendix H

STATE OF HAWAII
Department of Human Services
Med-QUEST Division

APPENDIX B

QUEST Integration CIS Referral Form Date: ____/____/_____

PART 1: REFERRAL SOURCE			
1. Who is referring this member to CIS? ☐ Self ☐ Family/Friend ☐ Internal Referral ☐ Another Health Plan ☐ Correctional Facility ☐ Medical Provider ☐ Nursing Home ☐ Social/Housing Services Provider ☐ Other Referral Source (specify):_____			
2. Referrer Name:		3. Referring Agency (if applicable):	
4. Referral Date:		5. Contact Phone Number:	
6. Contact Fax Number:		7. Contact E-Mail Address:	
PART 2: MEMBER INFORMATION			
8. Member First Name:	9. Member Last Name:	10. MI:	11. Date of Birth: _____/_____/_____
12. Member HMIS #:	13. Medicaid ID #:	14. CCS? ☐ No ☐ Yes	15. Health Plan: ☐ HMSA ☐ Kaiser ☐ AlohaCare ☐ Ohana ☐ United
16. Current Location/Address:		17. City, State, Zip:	
18. Mailing Address (if different from above):		19. City, State, Zip:	
20. Best Contact Phone Number:		21. Best Contact Email Address:	
22. Any friends or family who can help reach member? ☐ No ☐ Yes, Name/Phone:			
23. Does the member have interpretation needs? ☐ No ☐ Yes, Language:			
PART 3: PRESUMPTIVE MEMBER ELIGIBILITY INFORMATION (Subject to Verification)			
A member is eligible for CIS if they have <u>both</u> a health need and a homeless risk factor. Please indicate eligibility factors below. **ATTACH EVIDENCE OF CHECKED OFF HEALTH NEEDS and RISK FACTORS if known**			

PART A: HEALTH NEEDS-BASED CRITERIA	**PART B: HOUSING CRITERIA**
☐ Mental Health	☐ Sheltered or ☐ Unsheltered Homelessness
☐ Substance Use	☐ Risk of Imminent Eviction
☐ Complex Physical Health	☐ Frequent Institutional Stays

CIS Referral Form Instructions

Please fax the first page of this form to the appropriate provider with ATTN: QI CIS Program**.**

AlohaCare Fax: 808-973-0676	**HMSA** Fax: 808-948-8243	**Kaiser** Fax: 855-416-0995	**Ohana** Fax: 855-703-8078	**United** Fax: 866-314-3005	**CCS** Fax: 855-703-8078

If information in boxes 14 and 15 are unavailable or unknown, please fax to Med-QUEST at 808-692-8087.

STATE OF HAWAII
Department of Human Services
Med-QUEST Division

Appendix C

QUEST Integration (QI)
Consent to Participate in Community Integration Services (CIS) Form

First Name	Last Name	DOB	Preferred Name:	Medicaid ID #

PART A: HEALTH NEEDS-BASED CRITERIA	PART B: HOUSING CRITERIA
☐ Mental Health	☐ Sheltered or ☐ Unsheltered Homelessness
☐ Substance Use	☐ Risk of Imminent Eviction
☐ Complex Physical Health	☐ Frequent Institutional Stays

Consent to participate in CIS

☐ I have been informed about the housing services available through the CIS program.

☐ I understand that I have the right to pick the CIS provider that will deliver and monitor my services.

☐ I will participate in CIS visits and assessments.

☐ I understand that I can contact my CIS provider at any time I have questions about my housing plan or the services I receive.

Based on the information that has been presented to me, I want to [check one]:

[ ] ACCEPT: I voluntarily agree to enroll in **Community Integration Services**

[ ] REFUSE: I do not want **Community Integration Services**

REASON FOR REFUSAL: _____

_____ _____

Member or Advocate/Representative Signature **Date**

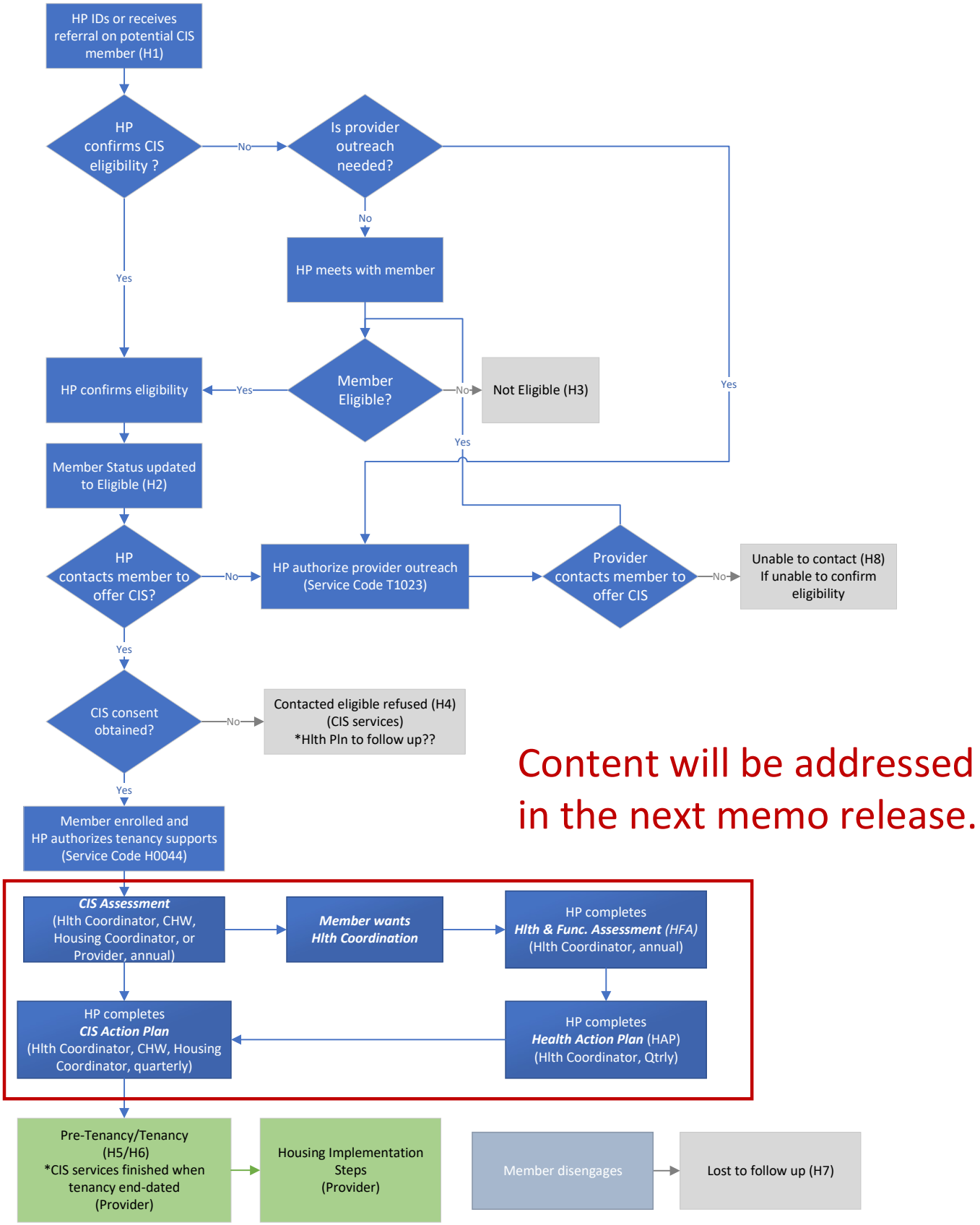
If signed by Member Advocate/ Representative,
Relationship to Member: _____
Phone: _____

_____ _____

CIS Services Agency or Health Plan Name: **Staff Name and Title**

Appendix H

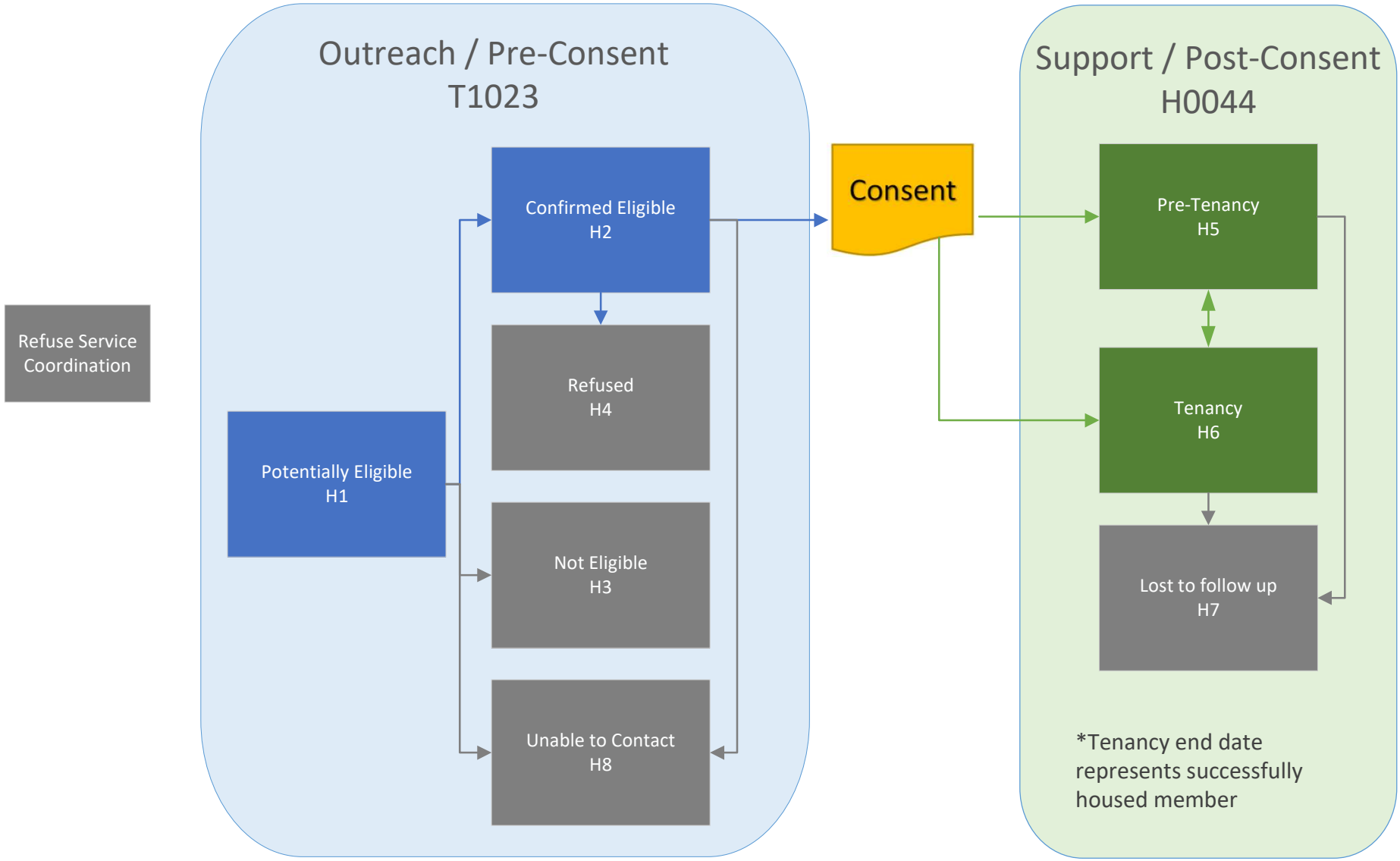
CIS Process



Content will be addressed in the next memo release.

Updated: 4/14/2023

CIS Member Status / Billing



Updated: 4/14/2023