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July 31, 2023

MEMORANDUM

MEMO NO.
QI-2314A [Update to QI-2314]
CCS-2303A [Update to CCS-2303]

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

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

SUBJECT: COMMUNITY INTEGRATION SERVICES (CIS) IMPLEMENTATION UPDATED GUIDELINES: CIS ASSESSMENT AND CIS ACTION PLAN

Introduction

UPDATED GUIDANCE v2 (July 2023)

This memo modifies CIS memo QI-2314, CCS-2303 (COMMUNITY INTEGRATION SERVICES (CIS) IMPLEMENTATION UPDATED GUIDELINES: ROLES AND RESPONSIBILITIES, FORMS, BILLING AND PAYMENT**, Released April 14, 2023).**

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

Any reference to days in this memo reflects calendar days.

Primary changes to the implementation guidelines described in this memo reflect revisions related to: CIS Assessment and CIS Action Plan. The CIS Process flow has also been updated (see Appendix H).

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 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 guidance specified below:

- **February 1, 2024, for changes related to the CIS Assessment and CIS Action Plan.**

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 and is intended to supplement (not supplant) other housing funding. Most importantly, 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 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~~. Community Care Services (CCS) members will receive CIS services through their

[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

CCS behavioral health plan. All other QI members will receive CIS through their QI health plan. References to responsibilities of QI Health Plans are therefore assumed to also apply equally to the CCS Health Plan for CCS members.

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.

The CIS eligibility criteria is intentionally broad to reduce barriers to services.

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 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 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 the CIS ~~member~~ assessment~~s 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. Heath and Functional Assessment (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.

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.~~

Upon referral notification, the QI health plan will independently verify that the member meets eligibility criteria.

For any new external referrals received, the QI health plan shall have no more than 30 days from the receipt of the referral to determine eligibility and authorize initial outreach and pre-tenancy/tenancy services. To minimize service delay, QI health plans are encouraged to determine eligibility and authorize initial outreach and pre-tenancy/tenancy services within fifteen (15) days after receipt of the external referral.

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.

For any new members identified as potentially eligible for CIS through any internal source, including QI health plan analytics, the QI health plan shall have 30 days from identification to determine eligibility and authorize initial outreach and pre-tenancy/tenancy services. To minimize service delay, QI health plans are encouraged to determine internal eligibility and authorize initial outreach and pre-tenancy/tenancy services within fifteen (15) days after the member is identified as potentially eligible.

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 quarterly report submissions.

Reporting Reference: (finalizing - additional guidance forthcoming)
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 of identification.~~

~~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 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 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.

QI health plan or CIS provider are encouraged to obtain consent within ~~have~~ ten (10) ~~business~~ days after outreach has been authorized or initiated by the health plan.

Reporting Reference: (finalizing - additional guidance forthcoming)
Signing of the consent form shall transition a member's CIS status from H2 (CIS – Contacted – Confirmed Eligible) to H5 (CIS – Housing Pre-Tenancy) or H6 (CIS- Housing Tenancy). The 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 capture all information on the consent form for reporting to MQD.

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 (HAP) 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.~~

4. 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-2314 as Appendix D. The CIS Member Assessment and Re-Assessment Tool is renamed in this memo as the CIS Assessment. The changes were made in response to provider/agency and health plan input.

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 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 thirty (30) forty-five (45) days after the date of consent to assess members newly enrolled in CIS complete the CIS Assessment and CIS Action Plan (see #6, CIS Action Plan); MQD encourages but does not require health plans/CIS providers to complete the assessment and CIS Action Plan 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.~~

The health plan or CIS provider shall have forty-five (45) days after the date of consent to complete the CIS Assessment and CIS Action Plan (see #6, 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 ~~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.

Reporting Reference: (finalizing - additional guidance forthcoming)
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.

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.~~

6. CIS Action Plan
The CIS Action Plan is provided in Appendix E.

This tool is a modified version of the CIS Health Action Plan Addendum provided in QI-2314 as Appendix E. The CIS Health Action Plan Addendum is renamed in this memo as the CIS Action Plan. The changes were made in response to provider/agency and health plan input.

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.

~~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 health plan or CIS provider shall have forty-five (45) days after the date of consent to complete the CIS Assessment and CIS Action Plan. The plan must be reviewed with, agreed to, and signed by the member and preparer before it is considered final.

The CIS Action Plan completed by a CIS Provider shall be submitted to the health plan within 30 days of completion. 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~~

Planning shall be a person-centered process, and the results of the CIS assessment shall guide the development of the CIS Action Plan. 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 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 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 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: 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. **Forms ~~and Reporting~~**

Health plans and providers shall use the following forms to collect data.

CIS members who accept health coordination must have an HFA & 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)	Unchanged	Appendix B (from QI-2314, CCS-2303)	N/A
CIS Consent Form	Unchanged	Appendix C (from QI-2314, CCS-2303)	N/A
HFA & HAP (if applicable)	Unchanged	Unchanged	Refer to health plan manual
CIS Assessment	Revised	Appendix D	N/A

CIS Action Plan	Revised	Appendix E	N/A

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

~~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 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). ~~If the member is in CCS, the forms shall also be shared with the member's QI health plan.~~

~~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.~~

The CIS Referral Form, CIS Assessment and CIS Action Plan 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.

Reporting Reference: (finalizing - additional guidance forthcoming)
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.

Providers should continue to collect data required by their respective health plan contracts in anticipation of audit and/or reporting requirements.

8. **Authorization, Billing and Payment**

An authorization from the health plan is required before services are provided or billed by the provider.

- If the provider submits a claim for CIS outreach 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 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.

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 outreach (T1023) and future pre-tenancy/tenancy services (H0044) should be issued at the same time. Payment for future pre-tenancy/tenancy services (H0044) is contingent on CIS member consent and eligibility confirmation.

CIS providers must be registered in HOKU with a provider type A3 or 77. Registered providers 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 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. Payments will reflect the full PMPM amount and will not be prorated. 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 reporting and auditing of provider documentation as part of provider oversight activities.

Reporting Reference: (finalizing - additional guidance forthcoming)
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 Codes	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 $ per member per month
CIS Support (after CIS consent form is completed)			
Support (post-consent)	• Transition, collaboration, and documentation	**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).

Effective immediately, POS 16 is appropriate to use when billing for services provided in temporary lodging such as on the street, in churches, in parking lots, in alleys, in encampments, or on the beach. These are examples of short-term accommodations that are not identified in any other POS code. (reference: QI-2327 FFS-23-13, CCS-2310 Street Medicine)

NOTE: Effective October 1, 2023, CMS is making a new POS code 27 available for tenancy and pre-tenancy services. MQD will provide additional guidance on POS 27 through a subsequent street medicine memo. (Reference:

https://www.cms.gov/medicare/coding/place-of-service-codes/place_of_service_code_set)

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.

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.

Reporting Reference: (finalizing - additional guidance forthcoming)
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 ~~Health~~ Action Plan ~~Addendums part of quarterly reassessments~~. This data shall be reportable to MQD as part of reporting requirements.

9. **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.

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.

10. **Reporting**

Reporting Reference: (finalizing - additional guidance forthcoming)

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).

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. **Qualifications of CIS Providers**

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. **Program Integrity Responsibility**

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. **Documentation**

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~~ CIS Action plan; and
- Signature or electronic signature using credentials, as applicable.

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. When the 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.

Reporting Reference: (finalizing - additional guidance forthcoming)
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

Reporting Reference: (finalizing - additional guidance forthcoming)
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~~ 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.

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 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.~~

Community Care Services (CCS) members will receive CIS services through their CCS behavioral health plan.

Reporting Reference: (finalizing - additional guidance forthcoming)
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.

Reporting Reference: (finalizing - additional guidance forthcoming)
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) or H6 (CIS- Housing- Tenancy) to MQD.
Successful enrollment into status H5 (CIS – Housing – Pre-Tenancy) or H6 (CIS- Housing-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. **Special considerations for the Queen's Care Coalition (QCC)**

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~~ forms shall be sent to the Health Plan. Once received, the Health Plan shall review the CIS ~~Packet~~ forms 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. QCC shall be subject to the same reporting and documentation requirements as other CIS providers.

Table 4. CIS Activity Timeframe:

CIS Activity	Timeframe	Example using maximum allowed times: At risk individual referred to HP by family member on January 1, 2023
Internal Potential Eligible and New External Referrals	Up to 30 days to determine eligibility and authorize initial Outreach and Pre-Tenancy/Tenancy. To minimize service delay, encourage <15 days.	01/31/2023 – confirmed eligibility and pre-authorization for initial Outreach and Pre-Tenancy/Tenancy completed.
CIS Member Consent	Encourage to obtain consent within 10 days after outreach authorized or initiated by HP. (May be extended based on member need)	02/10/2023 – consent obtained.
CIS Assessment and CIS Action Plan	After consent is obtained, up to 45 days to complete CIS Assessment and CIS Action Plan.	03/27/2023 – CIS Assessment and CIS Action Plan completed.
	Submit all completed documents to HP within 30 days of completion.	04/26/2023 – CIS Assessment and CIS Action Plan submitted to HP.
CIS Report	Submit complete CIS Assessment and CIS Action Plan data within 30 days of submission of documents to HP.	05/26/2023 – CIS Assessment and CIS Action Plan data are available to submit in the next quarterly report due (07/01/2023).
CIS Assessment and CIS Action Plan	CIS Action Plan to be reviewed/updated every 90 days.	06/27/2023 – CIS Action Plan update due.

Table 5 Status Codes:

CIS Status Code	Description	Notes
H1	CIS – POTENTIALLY ELIGIBILE	Use this code for **potentially eligible members** who have been identified based on ICD codes or other evidence.

H2	CIS – CONFIRMED ELIGIBLE	Use this code for **confirmed eligible members, not yet consented** to participate in program services.
H3	CIS – NOT ELIGIBILE	Use this code for **not eligible members** who do not meet program requirements.
H4	CIS – ELIGIBILE REFUSED	Use this code for **eligible members, who refused to participate** in the program.
H5	CIS – HOUSING PRE-TENANCY	Use this code for **eligible members, consented** to enroll in CIS **Pre-Tenancy Services**.
H6	CIS – HOUSING TENANCY	Use this code for **eligible members, consented** to enroll in CIS **Tenancy Services**.
H7	CIS – ELIGIBLE LOST TO FOLLOW UP	Use this code for **enrolled members** (Pre-Tenancy or Tenancy Services) who have been **lost to follow up** with **3 or more unsuccessful attempts** by the health plan **in the past 3 months**.
H8	CIS – POTENCIALLY 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.**

Table 6. Appendices:

Appendix	Status
Appendix A-Responsibilities	Unchanged from QI-2105, CCS-2102
Appendix B-Referral	Unchanged from QI-2314, CCS-2303
Appendix C-CIS Consent Form	Unchanged from QI-2314, CCS-2303
Appendix D-CIS Assessment	Revised
Appendix E-CIS Action Plan	Revised
Appendix F-HPO Funding-CIS Funding	Unchanged from QI-2105, CCS-2102
Appendix G-HCBS-Member Rights	Unchanged from QI-2105, CCS-2102
Appendix H-Process Flow	Revised
Appendix I-CIS Report Packet	To be released in next memo update

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APPENDIX D
CIS Assessment
(Initial/Re-enrollment)

Part I: Agency Information

CIS Agency:	CIS Provider ID:	Interviewer Name & ID (If applicable):
Date Assessment Initiated:	Date Assessment Completed:	

Part II: Member Information

Member First Name:	Member Last Name:	Middle Initial:	Medicaid ID#:	Birthdate: Age (Years):
HMIS ID#	☐ Unknown ☐ Not in HMIS	Medicaid Redetermination Date:	Other Relevant IDs (VA, etc.) (specify):	Other ID Number(s):
Current Residential Address/Location				
Street or Location:		City:		Zip Code:
Mailing Address (if different from current address)				
Street:		City and State:		Zip Code:

Contact Information	Phone Number	Can receive texts?	Email Address:	Any friends or family who can help reach you? Yes ☐ No ☐ If yes, please specify:	Contact Name:
	1.	Yes ☐ No ☐			Contact Ph Number:
	2.	Yes ☐ No ☐			Relationship to Member:

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CIS Assessment

(Initial/Re-enrollment)

Income		
Anticipated Total Monthly Income $	Anticipated Amount Available for Rent $	Is participant eligible for or receiving SSI? □ Yes □ No
Is Member receiving TANF? ☐ Yes ☐ No	Do you have a Legal Guardian/Power of Attorney/Rep Payee to assist in decision making? ☐Yes ☐ No If yes, person's name and contact information:	
Household Composition		
Number of additional household members: Adults _____ Children (under 18) _____	Does participant require a live in caregiver? □ Yes □ No	Does participant want a roommate? □ Yes □ No □ Maybe
Homeless Status		
□ At-risk of homelessness □ Homeless for less than 1 continuous year □ Multiple times homeless but not chronically* homeless □ Chronically homeless **Chronically homeless: homeless for 1 continuous year or more or 4 times homeless in last 3 years (that add up to 1 year)*		
Transportation		
Participant has a car □ Yes □ No		
Participant has TheHandi-Van, Paratransit Services, or TheBus pass □ Yes □ No		
Participant has other transportation options □ Yes □ No If yes, please specify:		
Veteran Status		
Has participant ever served on active duty in US Armed Forces? □ Yes □ No		
Housing Barriers		
Rental History □ Poor rental history □ Rental history with no issues □ No rental history		
Credit History □ Poor credit history □ Credit history with no issues □ No credit history		
Criminal History □ Has criminal history □ Criminal history with no issues □ No criminal history		
Eviction History □ Has Eviction history □ Eviction history with no issues □ No eviction history		
Has participant applied for a Housing Choice Voucher (Section 8)? □ Yes □ No		
Has participant applied for Public Housing? □ Yes □ No		
List any other housing that participant has applied for:		

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CIS Assessment

(Initial/Re-enrollment)

What were the primary reasons that caused you to experience homelessness (last occurrence if multiple) or have placed you at risk of homelessness?

Mental Health or Substance Use Disorder		*Physical Health Condition or Disability*		*Stress and Violence*		*Economic Reasons*	
☐	Alcohol or drug use	☐	Illness or medical problem	☐	Divorce/separation	☐	Loss of public housing or section 8 voucher
☐	Left a substance abuse treatment program and had nowhere to go	☐	Released from a hospital with nowhere to go	☐	Death in the family or death of a loved one	☐	Loss due to foreclosure including eviction from a foreclosed rental property
☐	Mental illness	☐	Disabled	☐	Family or domestic violence	☐	Evicted from a foreclosed rental property
☐	Other reasons exacerbated by mental health disorders or substance abuse	☐	Other reasons exacerbated by physical health conditions or disabilities	☐	Argument with family or friends	☐	Released from jail or prison and had nowhere to go
		☐	COVID-19 related	☐	Loss of housing due to non-economic reasons (house fire, lease violation, etc.)	☐	Unable to pay rent
				☐	Relocation or transition from another state	☐	Unable to pay mortgage
						☐	Lost job
						☐	SSI or SSD cut off or benefits canceled

Other reasons:

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CIS Assessment
(Initial/Re-enrollment)

Part III: Preferences

Living Arrangements				
□ Supervised Group Home □ Shared Apartment or Home □ Single Occupancy Apartment □ Group home (i.e. foster home) □ Independent rental □ Living with family/friends				
How many bedrooms does the participant want? □ Studio □ 1 bedroom □ 2 bedrooms □ 3 bedrooms □ 4 bedrooms				
□ Oahu	○ Honolulu	○ Windward	○ Central	○ Leeward
□ Hawaii	○ East	○ West	○ North	
□ Kauai				
□ Maui	○ Kahului	○ Kihei	○ Lahaina	
□ Molokai				
□ Lanai				
What specific areas does the person want to live? _____				
Does household have any pets? □ Yes □ No If yes, type and # of pets:				
Accessibility Needs				
□ No physical accessibility needs □ No stairs/ground floor □ Doorways at least 32 inches wide □ Front knob on appliances □ Roll in shower □ Grab bars in bath □ Lever door handles □ Other (please specify):				

Other Preferences				
Air conditioning	□ High □ Medium □ Low □ None		Parking available	□ High □ Medium □ Low □ None
Community area	□ High □ Medium □ Low □ None		Pet friendly	□ High □ Medium □ Low □ None
Exercise room	□ High □ Medium □ Low □ None		Public Transportation	□ High □ Medium □ Low □ None
Laundry on-site	□ High □ Medium □ Low □ None		Smoking allowed	□ High □ Medium □ Low □ None
Other (please specify)				

Part IV: Housing Readiness

Housing Documents
Participant has access to the following housing documents: Government issued picture identification □ Yes □ No Social security card □ Yes □ No Birth certificate □ Yes □ No Proof of income letter from Social Security □ Yes □ No Current bank statements □ Yes □ No Other income and asset information □ Yes □ No □ Not applicable
When will participant be ready for housing? □ Immediately □ Within 3 months □ Within 6 months □ Within a year □ A year or more □ Other (please specify):

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APPENDIX E
CIS Action Plan

☐ Initial ☐ Quarterly

Part I: Agency Information

CIS Agency:	CIS Provider ID:	Interviewer Name & ID (If applicable):
Date Initiated:	Date Completed:	

Part II: Member Information

Member First Name:	Member Last Name:	Middle Initial:	Medicaid ID#:	Birthdate: Age (Years):
HMIS ID#	☐ Unknown ☐ Not in HMIS	Medicaid Redetermination Date:	Other Relevant IDs (VA, etc.) (specify):	Other ID Number(s):
Current Residential Address/Location				
Street or Location:		City:		Zip Code:
Mailing Address (if different from current address)				
Street:		City and State:		Zip Code:

Contact Information:	Phone Number	Can receive texts?	Email Address:	Any friends or family who can help reach you? Yes ☐ No ☐ If yes, please specify:	Contact Name:
	1.	Yes ☐ No ☐			Contact Ph Number:
	2.	Yes ☐ No ☐			Relationship to Member:

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CIS Action Plan

Read to member: I am going to ask you some questions about your health, well-being, housing history and access to resources. This information will help us understand what is important to you and find out which services best suit your needs. If you do not want to answer a question, you don't have to.

Part III: Member Health and Well-being

1. Would you say that in general your health is:	☐ Excellent	☐ Very Good	☐ Good	☐ Fair	☐ Poor
2. Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?				Number of Days _____	
3. Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?				Number of Days _____	
4. During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?				Number of Days _____	

Part IV: Member Housing

5. In the last 30 days, how many days have you lived: (enter number of days)	Outside (e.g., street, car, camper/RV or park)	at an emergency shelter	at a temp/transitional shelter	in a supervised group home	in a shared apartment	in an independent apartment
	_____ days	_____ days	_____ days	_____ days	_____ days	_____ days
6. Do you have any new accessibility needs?	☐ Yes*	☐ No	*6a. If yes, what are your accessibility needs?			

7. Are you currently housed?	☐ Yes. If **yes**:	☐ No. If **no**:
	7a. What type of housing: ☐ Permanent ☐ Temporary/Transitional ☐ Institutional ☐ Other 7b. Are you newly housed since the last assessment: ☐ Yes ☐ No	7c. Have you lost housing since last assessment: ☐ Yes ☐ No

8. **Tenancy Only:** Are you satisfied with your current housing?	☐ Yes	☐ No*	*8a. If no, what are your concerns?

Part V: Services/Resource Utilization

Services/Resources	USED this service (past 30 days)	NEED this service	Not interested in this service
Financial			
1. Financial help for rent/rent subsidies, utilities, or other one-time costs	☐	☐	☐
2. Budgeting Assistance/Money Management; establishing credit; financial counseling	☐	☐	☐
Housing			
3. Housing Documents; ID assistance	☐	☐	☐
4. Rental housing information; applications; interviews; appeals; CES	☐	☐	☐
5. Finding accessible/affordable housing that meets my/my family's needs	☐	☐	☐
6. Emergency shelter/Temp housing/Transitional housing	☐	☐	☐
7. Permanent housing	☐	☐	☐
8. Landlord mediation	☐	☐	☐
9. Development of/Changes to Eviction Prevention Plan	☐	☐	☐
10. Ongoing housing subsides	☐	☐	☐
Healthcare			
11. Accessing Medical services; vision; nutrition/dietitian, dental; primary care	☐	☐	☐
12. Accessing Mental health services and social supports; crisis services	☐	☐	☐
13. Substance abuse treatment services	☐	☐	☐
14. Compliance with Medical/Mental Health/Substance Use Plan of Care and medications	☐	☐	☐
Health Coordination			
15. Health Coordination by Health Plan *If member needs or refuses health coordination, refer to health plan for review*	☐	☐	☐

Social Services			
16. Securing/maintaining Medicaid Eligibility	☐	☐	☐
17. Benefits services, including TANF, SSI and SSDI	☐	☐	☐
18. Accessing food/necessities; soup kitchen or food pantry; cooking	☐	☐	☐
19. Legal assistance; probation; parole	☐	☐	☐
20. Clothes closet	☐	☐	☐
21. Day center with telephones, mailrooms, or restrooms	☐	☐	☐
Employment Assistance			
22. Job readiness, job search, or employment assistance, vocational services; education, volunteer supports	☐	☐	☐
Transportation			
23. Transportation assistance	☐	☐	☐
Other Services/Resources			
24. Individual and/or family Counseling, skills coaching; support Groups, natural supports, anger management/Domestic violence/AA-NA	☐	☐	☐
25. Caregiving for children and other relatives	☐	☐	☐
26. End of life planning	☐	☐	☐
27. Personal Care (Long-term Support Services)	☐	☐	☐

Part VI: Person-Centered Housing Goals

28. What are your **housing** goals (short-term and long-term)? **(Complete during initial assessment. Review and revise as needed quarterly)**
a.
b.
c.
d.

Department of Human Services
Med-QUEST Division

CIS Action Plan

Part VII: Other Interviewer Notes and Observations:

29. Person-centered plan meeting or revision plan meeting held with member: ☐ Yes ☐ No
30. CIS assessment completed during this quarter: ☐ Yes ☐ No
31. Notes:

Part VIII: Discharge from CIS:

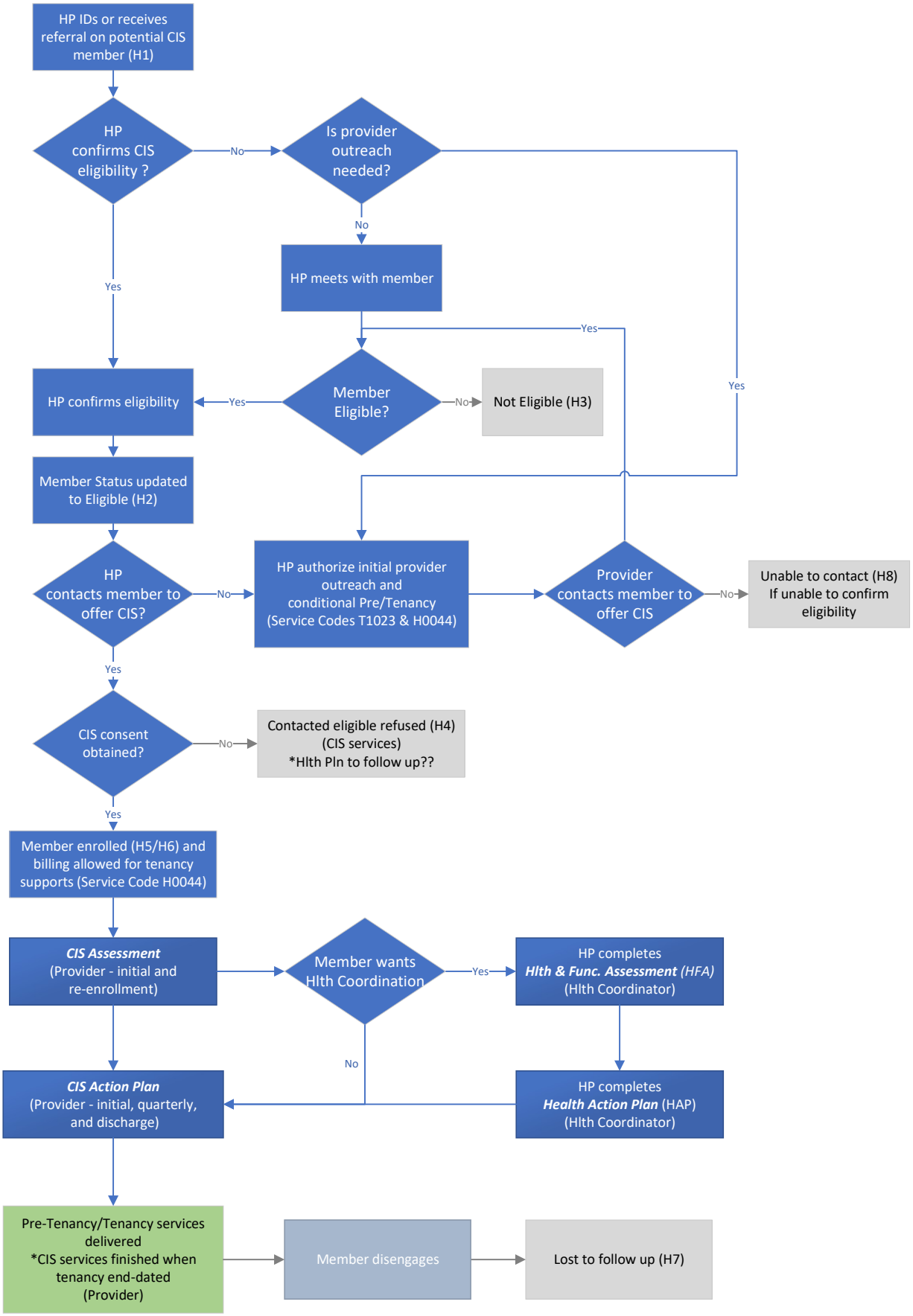
32. Is member exiting CIS?	☐ Yes*	☐ No	*If yes, what type of housing is the member exiting to/remaining in? ☐ Permanent ☐ Temporary/Transitional ☐ Institutional ☐ Place not meant for habitation (e.g., car, beach, street, park, etc.) ☐ Other (Deceased, Relocated out of state)_____ Date of Discharge *(mm/dd/yy)*: / /

Signatures
This information was collected in good faith and is as accurate as possible:

Member Signature	Member Advocate Signature (if applicable)	Date
CIS Interviewer Signature	CIS Interviewer Name & Title	Date

APPENDIX H

CIS Process



Updated: 6/27/2023