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January 2, 2026

MEMORANDUM

MEMO NO.
QI-2601 [Update to QI-2314D]
CCS-2601 [Update to CCS-2303D]

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

FROM: Meredith Nichols
Acting Med-QUEST Division Administrator

SUBJECT: COMMUNITY INTEGRATION SERVICES PLUS (CIS+) IMPLEMENTATION UPDATED GUIDELINES: MEDICAL RESPITE – DECEMBER 2025

INTRODUCTION

This memo modifies CIS+ memo QI-2314D/CCS-2303D (COMMUNITY INTEGRATION SERVICES (CIS+) IMPLEMENTATION UPDATED GUIDELINES: ROLES AND RESPONSIBILITIES, FORMS, BILLING AND PAYMENT, Released October 2025).

The text of CIS memo QI-2314D/CCS-2303D is incorporated into this revision, identified as CIS+ memo **QI-2601/CCS-2601**. Updated guidance is inserted as shaded text. Voided text from QI-2341D/CCS-2303D is stricken. **Unless specified in this memo, the implementation guidelines as stated in QI-2314D/CCS-2303D are unchanged.**

Any reference to days in this memo reflects calendar days.

The primary edits to **QI-2314D/CCS-2303D** were to allow members currently residing in medical respite to begin receiving the Medicaid benefit during the transition period, add that the CIS+ Member Consent form remains valid as long as the member is in the program, clarify that members receiving medical respite should receive housing navigation supports unless they decline or are ineligible, and update the person-centered services plan deadline from 72 hours to three calendar days.

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CIS+ Program Background

1. Program Description and Context

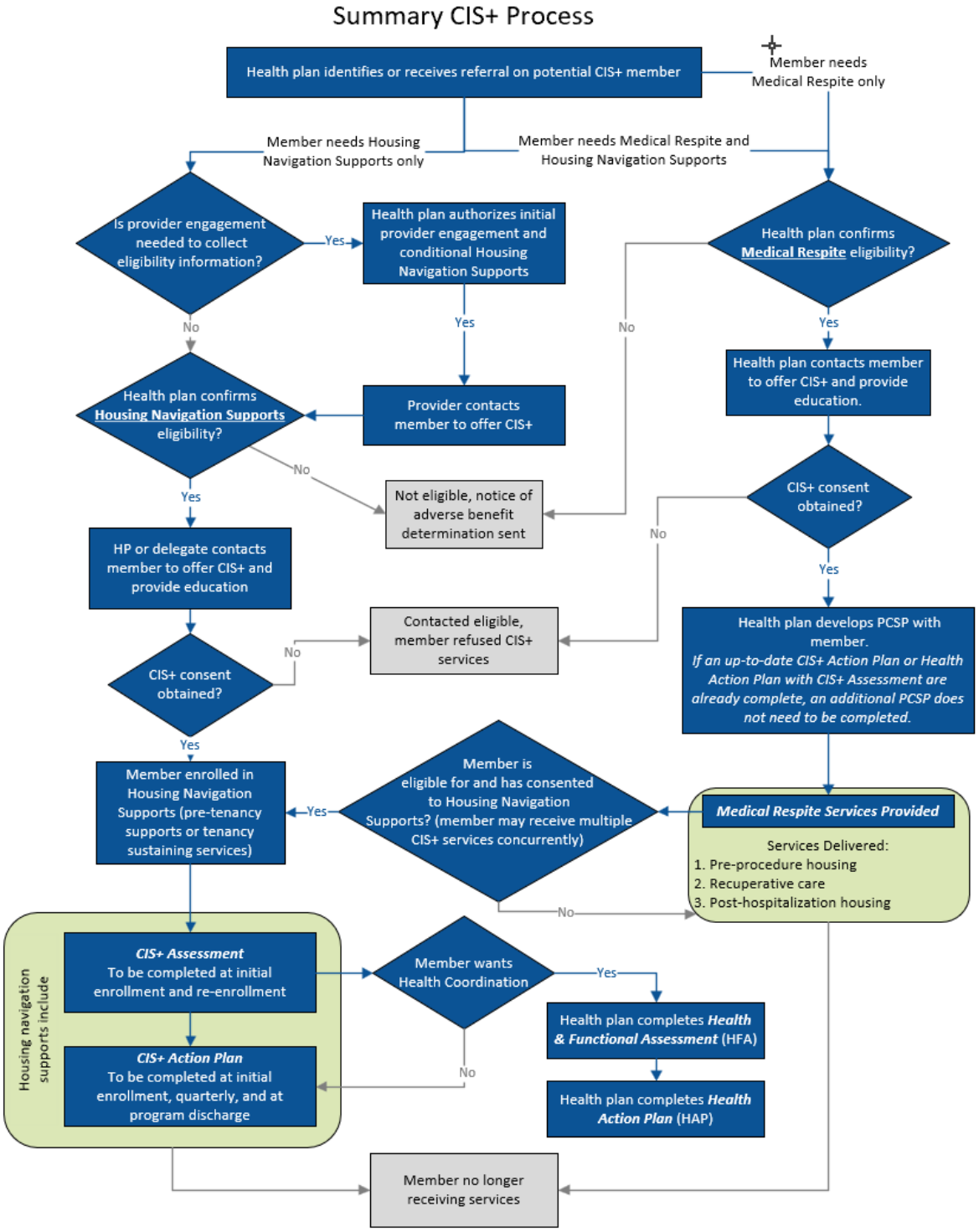
The purpose of this document is to outline the requirements of the Community Integration Services Plus (CIS+) program and provide health plans with updated guidance on benefit parameters, eligibility, health plan responsibilities, forms, and other program details. The CIS+ benefits described in this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

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 Plus (CIS+) – previously named Community Integration Services (CIS)— assists eligible members with becoming fully integrated members of the community as well as achieving improved health outcomes and life satisfaction. Effective January 1, 2026, the CIS+ program includes two types of housing-related benefits: housing navigation supports and medical respite. Med-QUEST Division (MQD) intends to add additional housing support benefits to CIS+ in a phased approach. Figure 1 below provides a high-level summary of the CIS+ program process, with the new medical respite benefit and person-centered service plan (PCSP) included. For a more detailed CIS+ Process graphic that includes additional steps, billing codes, and CIS+ Status Codes, see Appendix H – CIS+ Process Flow.

[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

Figure 1: Summary CIS+ Process



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2. Service Descriptions and Limits

The CIS+ program encompasses two categories of benefits: housing navigation supports include both pre-tenancy support and tenancy sustaining services, while medical respite includes short-term pre-procedure housing, short-term recuperative care, and short-term post-hospitalization housing.

Detailed descriptions of the responsibilities associated with each benefit are outlined in Appendix A – Responsibilities. All CIS+ services must be provided in a way that is culturally responsive and ensures meaningful access to language services.

Housing Navigation Supports Services

When paired with affordable housing[2], housing navigation supports are a cost-effective way to engage members experiencing homelessness, help reduce homelessness, and increase housing stability. Housing navigation supports are intended to help members attain and maintain safe, affordable housing. CIS+ seeks to engage the member in self-care and personal management by establishing a personalized housing support plan (See Appendix E – CIS+ Action Plan) that is holistic and reflective of member preferences and goals.

Health plans may authorize services in up to three month increments, as needed, provided the individual remains eligible.

There are two housing navigation supports:

1. Pre-tenancy Supports help members in identifying and securing housing and preparing to become successful tenants. Supports may include assessing housing needs and preferences, assisting with documentation and benefits, linking the individual to immediate basic needs and supportive services, coordinating the housing search and move-in process to promote stable community living, and other similar services.

2. Tenancy Sustaining Services support members in maintaining stable housing and independent living sustainability. Supports may include tenant/landlord education, tenant coaching on independent living, financial management, household skills, tenant assistance with community integration and inclusion to help develop natural support networks, connecting the individuals to community resources and benefits, and providing referrals to address housing-related legal or tenancy issues, as needed.

[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

Medical Respite Services

Medical respite services (also referred to as "episodic interventions" in the Section 1115 Demonstration approval) provide eligible members short-term room and board with clinical services and other supports. The benefit is designed to support members with short-term needs to recover from or prepare for clinical events in safe, supportive housing. The benefit is not designed to meet members' long-term care needs.

Medical respite services are time-limited based on clinical and social need. Each medical respite benefit may be authorized for limited time periods, not to exceed a combined six months within a rolling 12-month period. The rolling 12-month period starts on the day that medical respite benefits begin. Health plans are responsible for monitoring these benefit limits. If a member changes health plans, the former health plan is responsible for communicating the dates and length of medical respite stays as described in QI contract Section 9.3.B. In advance of January 1, 2026, MQD may update the health plan change and transition of care file template (QI-2419A) to include basic information on medical respite benefit usage.
There are three distinct medical respite services:

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

Connection between Medical Respite and Housing Navigation Support

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

All members receiving medical respite should be enrolled in housing navigation supports, unless they decline participation or are otherwise ineligible. Members receiving short-term recuperative care or short-term post-hospitalization housing are automatically eligible for housing navigation supports. However, members receiving short-term pre-procedure housing are not automatically eligible; those receiving short-term pre-procedure housing may or may not have a complex behavioral or physical health need that would qualify them for housing navigation supports.

Health plans and/or CIS+ providers shall provide education on CIS+ services at key milestones:

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

3. Eligibility Criteria

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

The CIS+ eligibility criteria are intentionally broad to reduce barriers to services. MQD will publicly maintain CIS+ eligibility criteria on the Hawai'i Medicaid State Plan and Demonstration webpage[3] (see Section 1115 Demonstration Renewal for 2024). Health plans shall maintain

[3] https://medquest.hawaii.gov/en/about/state-plan-1115.html

these criteria on a public-facing webpage by January 1, 2026. In the future, when the public-facing criteria change, the website content shall be updated within one month of MQD notice.

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

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

Social Risk Factor Definition

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

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

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

- *At risk of homelessness.*
  (1) An individual or family who:
    (i) Does not have sufficient resources or support networks, *e.g.,* family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the "Homeless" definition; and
    (ii) Meets one of the following conditions:
      (A) Has moved because of economic reasons two or more times during the sixty (60) days immediately preceding the application for homelessness prevention assistance;
      (B) Is living in the home of another because of economic hardship;
      (C) Has been notified in writing or verbally that their right to occupy their current housing or living situation will be terminated within 21 days after the

date of application for assistance;

(D) Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;

(E) Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;

(F) Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or

(G) Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan.

- *Homeless.*

(1) An individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning:

(i) An individual or family with a primary night-time residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground;

(ii) An individual or family living in a supervised, publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state, or local government programs for low-income individuals); or

(iii) An individual who is exiting an institution where he or she resided for ninety (90) days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution;

(2) An individual or family who will imminently lose their primary nighttime residence, provided that:

(i) The primary nighttime residence will be lost within 21 days of the date of application for homeless assistance;

(ii) No subsequent residence has been identified; and

(iii) The individual or family lacks the resources or support networks, e.g., family, friends, faith-based or other social networks needed to obtain other permanent housing;

(3) Unaccompanied youth 18 to 25 years of age, or families with children and youth, who do not otherwise qualify as homeless under this definition, but who:

(i) Are defined as homeless under section 387 of the Runaway and Homeless Youth Act (42 U.S.C. 5732a), section 637 of the Head Start Act (42 U.S.C. 9832), section

41403 of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2), section 330(h) of the Public Health Service Act (42 U.S.C. 254b(h)), section 3 of the Food and Nutrition Act of 2008 (7 U.S.C. 2012), section 17(b) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)), or section 725 of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a);

(ii) Have not had a lease, ownership interest, or occupancy agreement in permanent housing at any time during the 60 days immediately preceding the date of application for homeless assistance;

(iii) Have experienced persistent instability as measured by two moves or more during the 60-day period immediately preceding the date of applying for homeless assistance; and

(iv) Can be expected to continue in such status for an extended period of time because of chronic disabilities, chronic physical health or mental health conditions, substance addiction, histories of domestic violence or childhood abuse (including neglect), the presence of a child or youth with a disability, or two or more barriers to employment, which include the lack of a high school degree or General Education Development (GED), illiteracy, low English proficiency, a history of incarceration or detention for criminal activity, and a history of unstable employment; or

(4) Any individual or family who:

(i) Is fleeing, or is attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the individual or a family member, including a child, that has either taken place within the individual's or family's primary nighttime residence or has made the individual or family afraid to return to their primary nighttime residence;

(ii) Has no other residence; and

Lacks the resources or support networks, e.g., family, friends, faith-based or other social networks, to obtain other permanent housing

Clinical Need Definitions

Table 1: CIS+ Clinical Need Definitions

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

Short-term Recuperative Care Need	A member must be in institutional care, which may include an acute care hospital, state mental health hospital, nursing facility, or other inpatient or institutional setting. Institutional care settings do not include the ED. **And**, a member must have ongoing physical or behavioral health needs as determined by a qualified health professional that would otherwise require continued institutional care if not for receipt of recuperative care. *Note, MQD is implementing eligibility criteria in a phased approach and plans to expand access to short-term recuperative care to members in the emergency department or at risk of institutionalization at a later date.*	• Short-term recuperative care • Pre-tenancy supports • Tenancy sustaining services
Short-Term Post-Hospitalization Housing Need	A member must be in institutional care, which may include an acute care hospital, state mental health hospital, nursing facility, or other inpatient or institutional setting. Institutional care settings do not include the ED. **And**, a member must have ongoing physical or behavioral health needs as determined by a qualified health professional that would otherwise require continued institutional care if not for receipt of short-term post-hospitalization housing.	• Short-term post-hospitalization housing • Pre-tenancy supports • Tenancy sustaining services

Medical Respite Clinical Appropriateness

In addition to meeting the benefit eligibility criteria above, MQD has outlined guidance on the clinical appropriateness of medical respite for members.

Health plans are responsible for ensuring that members receive care in the most appropriate setting. Medical respite is not intended for members with high-acuity needs requiring intensive

or specialized care. Instead, the benefit is designed for individuals who need short-term housing and support to prepare for or recover from a physical or mental health event.

Because medical respite providers differ in capacity and capabilities, health plans shall work closely with each provider to confirm that the facility can meet the member's clinical and support needs. Health plans shall consider members' clinical needs and the capabilities of a specific provider when determining the medical respite placement best suited for the member's needs.

Generally, a member receiving medical respite will:

1. Have full decision-making capacity;
2. Be able to live independently;
3. Be independent with regard to activities of daily living (ADLs) and instrumental activities of daily living (IADLs), except for needing short-term assistance with regaining the ability to perform ADLs and IADLs as part of the recuperative process;
4. Have an acute or chronic clinical issue that is likely to resolve, improve greatly, or stabilize through a medical respite stay; and
5. Not have one or more of the following:
    a. Conditions that require services the medical respite provider site cannot support (this may vary by provider site and capacity);
    b. Requirement for medical help to take medications;
    c. Incontinence that cannot be self-managed; and
    d. High-acuity behavioral health needs requiring inpatient hospitalization.

Health plans may rely on the qualified health professional's determination that the member would otherwise require continued institutional care. Specific forms or level of care assessments are not required.

4. Health Plan and CIS+ Provider Roles

Health plans are responsible for CIS+ benefit administration. Successful administration of the CIS+ benefit will require plans to collaborate with a range of stakeholders, including CIS+ providers. The main activities associated with the CIS+ program and a high-level summary of health plan and provider roles in that activity are outlined in Table 2. Provider responsibilities associated with each benefit are outlined in Appendix A – Responsibilities.

Table 2: Health Plan and Provider Responsibilities

Task	Health Plan Role	CIS+ Provider Role
Member Identification	Responsible, see Identification of Potential CIS+ Members for more detail.	May provide community referrals to health plans on behalf of members.
Member Engagement	Responsible, member engagement for housing navigation supports may be delegated to CIS+ providers.	May conduct member engagement for housing navigation supports, if authorized by the health plan.
Eligibility Verification	Responsible, see Eligibility Criteria for more detail.	May collect information used by the health plan for eligibility verification.
Service Authorization	Responsible, health plans must authorize CIS+ services based on clinical and social need.	Cannot make service authorization decisions.
Providing CIS+ Program Education and Soliciting Consent	Responsible, health plans may conduct education and solicit consent, or delegate to CIS+ providers for housing navigation supports.	May conduct education and solicit consent from the member for housing navigation supports, if authorized by the health plan.
CIS+ Assessment	Responsible, health plans must ensure that members receiving housing navigation supports have a complete CIS+ Assessment (may delegate the task to a CIS+ provider). See CIS+ Assessment for more detail.	May conduct the CIS+ Assessment, if authorized by the health plan.

Person-centered Service Plan (PCSP) *(includes CIS+ Action Plan, Health Action Plan, and ~~possible Custom~~ Medical Respite PCSP)*	Responsible, health plans must complete a PCSP for each CIS+ member. Members receiving housing navigation supports must have at least the CIS+ Action Plan. Members receiving medical respite can meet PCSP requirements in one of three ways. Health plans may delegate to providers to support the completion of PCSPs; PCSPs with delegated components must be reviewed and approved by the health plan. See Person Centered Service Plan and CIS+ Action Plan for more details.	May support the development of a PCSP, if authorized by health plan.
CIS+ Benefit Coordination	Responsible, health plan must engage CIS+ providers and coordinate services.	Not responsible.
CIS+ Benefit Limit Monitoring	Responsible, health plan must track medical respite benefit limits.	Not responsible.
Service Provision	Responsible, health plan must ensure that services are provided as documented in the member's PCSP.	Responsible, CIS+ providers are responsible for service provision, as documented in the member's PCSP and as authorized by the health plan. See Appendix A – Responsibilities for additional detail on benefit requirements and CIS+ provider responsibilities.
Reporting	Responsible, see Reporting for more detail.	Responsible, see Reporting for more detail.
Claiming	Responsible, health plan must pay CIS+ providers.	Responsible, CIS+ providers must submit a clean claim to health plans.
Registration/Contracting	Responsible, health plan must contract with CIS+ providers and maintain an adequate CIS+ provider network.	Responsible, CIS+ providers must register with Medicaid and additionally contract with health plans.

QI Health and Community Care Services (CCS) Plan Roles

For housing navigation supports and medical respite, the CCS plan administers the benefit for CCS members. For all other members, the QI health plan administers the benefit. In this context, references to "health plans" include both QI and CCS plans for CCS members.

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

Collaborative Team-Based Approach

MQD's preference for a team-based approach to the implementation of the CIS+ program remains unchanged and is re-emphasized. The health plans shall lead collaborative efforts to support provider agencies. Recommended collaboration includes orientation to and training on CIS+ implementation and monthly (at minimum) case conferences to discuss members enrolled in the CIS+ program. Case conferences should be used as an opportunity to troubleshoot and resolve any implementation issues, as well as to facilitate members' engagement in CIS+. Additionally, case conferences are an opportunity for health plans to ensure CIS+ members' access to medical services and/or other QI benefits for which they are eligible. When utilized, the monthly housing navigation supports benefit payments shall include services provided by all housing navigation support provider team members.

All health plans are <u>strongly encouraged</u> to participate in the Homeless Management Information System (HMIS).

5. <u>Other CIS+ Related Assessments</u>

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

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

arrange for these additional assessments to be completed.

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

6. Person-Centered Service Plan (PCSP)

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

Health plans may delegate completion of the PCSP to another entity (e.g., a hospital). Delegation must be documented, and the delegate must be able to educate the member on the full CIS+ program, including all benefits available and the benefit limits. Due to conflict of interest requirements, health plans may NOT delegate completion of the PCSP for medical respite to a medical respite facility. While the health plan or its delegate may conduct the person-centered planning process, health plans are ultimately accountable for this process and the authorization of CIS+ services based on members' eligibility and need. The person-centered planning processes can occur during the same visit as when the member provides consent to participate in the CIS+ program.

Table 3 provides guidance on how health plans can meet PCSP requirements, based on the specific CIS+ service a member is receiving. In cases where multiple options are available, health plans shall choose the approach that not only satisfies the person-centered planning requirements but also best fits the member's individual needs or supports timely connection to services. For members receiving medical respite, a PCSP should be developed within three calendar days ~~seventy-two (72) hours~~ of admission to a medical respite facility.

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

Table 3: Minimum Requirements for Person-Centered Service Planning for CIS+ Services

CIS+ Services the Member is Receiving	Mandatory PCSP
Housing Navigation Supports	(1) CIS+ Action Plan
Medical Respite	At least one of the following within three calendar days ~~seventy-two (72) hours~~ of admission to a medical respite facility: (1) CIS+ Action Plan (2) Health Coordination Services with Health Action Plan and CIS+ Assessment (3) ~~Custom~~ Medical Respite Person-Centered Service Planning

Medical Respite PCSP Option 1: CIS+ Action Plan

All members receiving housing navigation supports should have a CIS+ Action Plan. See the CIS+ Action Plan section for full details.

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

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

Medical Respite PCSP Option 3: ~~Custom~~ Medical Respite Person-centered Service Plan ~~Process~~

Health plans may use the Medical Respite PCSP in Appendix J for members receiving medical respite services. ~~Health plans can collaboratively design a standardized PCSP for members receiving medical respite services.~~ Because developing a CIS+ Action Plan or Health Action Plan may be time-intensive and challenging for members in an institution or recently discharged to complete the ~~custom PCSP~~ Appendix J option allows health plans to develop a streamlined PCSP with the member. This option may help facilitate the timely development of PCSPs within three calendar days ~~seventy-two (72) hours~~ of medical respite admission.

The ~~custom~~ complete medical respite PCSP should meet the following minimum standards:

- Identifies the member's needs, individualized strategies and interventions for meeting those needs, and barriers to meeting those needs.

- Is developed in consultation with the member and the member's chosen support network, as appropriate.
- Is reviewed and revised as appropriate at least every 12 months, when the member's circumstances or needs change significantly, or at the member's request.

7. <u>Identification of Potential CIS+ Members</u>

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

a. Health plan data analyses for Homelessness Z-Code (Z59 series), or other indications of homelessness (e.g., Z55-Z65 series used to document persons with potential health hazards related to socioeconomic and psychosocial circumstances, and other indicators of unusual utilization patterns or address information indicative of housing instability);
b. Health plan analyses of utilization data on members who are identified to be homeless or potentially homeless to establish health needs-based criteria;
c. Health plan members who were previously identified as homeless or at risk for homelessness but were assigned a status of H7 (CIS+ – Beneficiary Lost to Follow Up) or H8 (CIS+ – Unable to Contact) and subsequently disenrolled from the program;
d. Access to and verification of homelessness status within HMIS. MQD encourages health plans to establish data sharing agreements with HMIS that enable automated member-matching;
e. Member-matching against the HMIS/Coordinated Entry System (CES) By-Name List;
f. Welcome calls for new members/member surveys from health plan activities;
g. Quality improvement activities through health plan;
h. Health and Functional Assessment (HFA) assessments/re-assessments for members or other member engagement activities;
i. Referrals from Community Service Coordinators/Case Managers, or other healthcare providers;
j. Referrals from current homeless agencies, independent living providers, DHS and Continuum of Care (CoC) Homeless Assistance Agencies, Hawaii Public Housing Authority, Department of Health's (DOH) Alcohol and Drug Abuse Division (ADAD) and Adult Mental Health Division (AMHD);
k. Referrals from community-based organizations (CBOs), for example, food banks;
l. Medical provider referrals including, but not limited to, providers from inpatient, emergency department, nursing facility, primary care, community health centers, other clinical, and other institutional settings;
m. Referrals from MQD Medicaid eligibility workers, and other MQD staff;
n. Re-entry worker/system referrals for example from the Hawaii State Hospital (HSH), prisons, drug treatment facilities, etc.; and
o. Members, or their friends and family members.

Housing Navigation Supports Reporting Reference

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

8. CIS+ Referral and Eligibility Confirmation

CIS+ Referral

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

1. CIS+ Referral Form (Appendix B): Any member, individual, or organization can use this form to refer members for any CIS+ service.
2. Medical Respite Authorization Form (Appendix I): For health plans to authorize medical respite services, a qualified health professional must review and sign the medical respite authorization form.

CIS+ Referral Form

The CIS+ Referral Form is provided in Appendix B.

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

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

information. It is the health plan's responsibility to obtain and assure completeness of information and documentation to confirm eligibility for CIS+.

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

Medical Respite Authorization Form

The Medical Respite Authorization Form is provided in Appendix I.

To be approved for medical respite services, a clinician must send the health plan a Medical Respite Authorization Form. If the Medical Respite Authorization Form is completed, a CIS+ Referral Form is not needed. A qualified health professional (Doctor of Medicine/Doctor of Osteopathic Medicine/Nurse Practitioner/Physician Assistant) must review, approve, and sign the Medical Respite Authorization ~~referral~~ Form.

Health plans may require qualified health professionals to provide additional documentation to determine eligibility or the level of care the member needs. MQD anticipates that health plans will leverage the information provided in the Medical Respite Authorization Form to determine eligibility for medical respite benefits and coordinate with medical respite facilities to ensure the member's level of need aligns with what the medical respite setting is able to provide.

Medical Respite go-live transition: To allow members currently located in medical respite facilities to begin receiving the Medicaid benefit, a temporary transition exception is available through June 30, 2026. For the first two weeks after a medical respite provider is registered in HOKU and contracted with a health plan, a qualified health professional may submit a Medical Respite Authorization Form for a member who is already located in the medical respite facility, provided the member came to the medical respite facility from an institutional setting. For medical respite facilities that are registered in HOKU and contracted with health plans on January 1, 2026, Medical Respite Authorization Forms may be submitted for current medical respite occupants through January 14.

Eligibility Confirmation

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

Housing Navigation Supports

For any new external referrals for housing navigation supports received, or members identified as potentially eligible through any internal source, the health plan shall have no more than 30 days from the receipt of the referral to determine eligibility and authorize initial engagement and pre-tenancy supports/tenancy sustaining services. To minimize service delay, health plans are encouraged to determine eligibility and authorize initial engagement and pre-tenancy supports/tenancy sustaining services within 15 days after receipt of the external referral. For institutionalized members, health plans should complete the eligibility confirmation before discharge.

Medical Respite

Health plans have a maximum of seven days after receipt of the Medical Respite Authorization Form to conduct the eligibility screening. For members in an institution, health plans shall conduct eligibility screening before the member is discharged, within seven days. Once a member's eligibility is confirmed, health plans will authorize medical respite services for a defined time period and work with CIS+ medical respite providers to ensure the member is placed in an appropriate setting.

Eligibility Verification Backlogs

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

Appeals and Grievances

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

Housing Navigation Supports Reporting Reference

Health plans are expected to identify potentially eligible CIS+ beneficiaries through data analytics at least once per quarter. Data analytics includes QI members who were previously at

any stage of CIS+, including beneficiaries who were disenrolled from the program (especially when disenrolled due to lack of contact). If these members are re-identified and potentially eligible for CIS+, they shall be assigned a status code of H1 (CIS+ – Potentially Eligible) or HA (CIS+ – Potentially Eligible with engagement authorized). Additionally, referrals from other QI health plan staff are expected to be received and evaluated on an ongoing basis.

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

9. CIS+ Member Consent

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

Once a member is deemed eligible for CIS+, the health plan or CIS+ provider shall contact the member and obtain consent to participate in the program. If the member is in immediate need of medical respite services, the health plan should contact the member and obtain consent as soon as feasible. See Appendix H – CIS+ Process Flow for a depiction of when to use the CIS+ Member Consent Form.

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

Consent for Housing Navigation Supports

For housing navigation supports, health plans and CIS+ providers are encouraged to obtain consent within 10 days after engagement has been authorized by the health plan.

Consent for Medical Respite Services

Due to the time-sensitive nature of medical respite services, health plans or their designee should obtain consent as soon as possible, within a maximum of 10 days.

- *Members in an institution:* Consent must be obtained prior to discharge.
- *Members with upcoming procedure:* If the member requires short-term pre-procedure housing in less than 10 days, consent should be obtained as soon as possible to avoid delays in care.

Housing Navigation Supports Reporting Reference

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

10. Housing Navigation Support Post-Consent Transition Period

For housing navigation supports, MQD recognizes that there is a period of transition post-consent during which the member is enrolled in CIS+ but awaiting completion of the CIS+ Assessment and/or Health and Functional Assessment (HFA). To ensure continued member engagement, establish trust, eliminate barriers to services, and prepare for the delivery of pre-tenancy supports and tenancy sustaining services, preparatory activities which further the pursuit of stable housing may be delivered during this transition period under HCPCS code H0044.

11. CIS+ Assessment

The CIS+ Assessment is provided in Appendix D.

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

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

The CIS+ assessment has four sections:

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

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

The health plan or CIS+ provider shall have 45 days 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 process, the member is identified to be in immediate danger, or is currently a threat to self or others, the health plan shall take immediate action to provide resources to stabilize the members, regardless of the member's prioritization or acuity score to receive CIS+ services.

Reporting Reference

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

12. CIS+ Action Plan

The CIS+ Action Plan is provided in Appendix E. The CIS+ Action Plan is required for members receiving housing navigation supports and is one of three PCSP tools that a health plan can use for members receiving medical respite (see the Person Centered Service Plan section for more details).

This tool is a modified version of the CIS+ Health Action Plan provided in QI-2314C as Appendix E.

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

The health plan or CIS+ provider shall have 45 days 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. When the need for additional CIS+ services is identified, the CIS+ Action Plan should be reviewed by the health plan, which has the authority to authorize other CIS+ services.

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

The results of the CIS+ Assessment shall guide the development of the CIS+ Action Plan. The plan shall be developed through a person-centered process in consultation with the member and the member's chosen support network, as appropriate. CIS+ service planning shall be conducted with the member, and the CIS+ Action Plan shall capture the members' CIS+ services and support needs. The CIS+ Action Plan has eight sections:

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

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

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

Person-centered CIS+ Crisis Plan and Eviction Prevention Plan

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

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

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

13. Forms

Health plans and providers shall use the following forms to collect data (see Table 4). CIS+ members who accept Health Coordination must have an HFA & HAP completed. The CIS+ Assessment may be used as a stand-alone document to identify the CIS+ needs of members who opt out of Health Coordination Services.

Table 4: CIS+ Forms

Form	Version	Cadence	Location
CIS+ Referral Form (optional)	Updated October 1, 2025	Anytime, for any benefit	Appendix B
CIS+ Consent Form	Updated October 1, 2025	At enrollment and re-enrollment, before services are provided	Appendix C
HFA & HAP (if applicable)	Refer to Health Plan Manual	Optional if member opts for health coordination services; consider for members eligible for medical respite	Unchanged
CIS+ Assessment	Updated October 1, 2025	At enrollment and re-enrollment, for housing navigation supports	Appendix D

CIS+ Action Plan	Updated October 1, 2025	Every 3 months, at the member's request, or when the member's circumstances or needs change significantly, for housing navigation supports	Appendix E
Medical Respite Authorization Form	New October 1, 2025	When authorizing medical respite benefits	Appendix I

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

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

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

Reporting Reference

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

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

14. Authorization, Billing Codes, and Rates

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

- An authorization from the member's health plan is required before CIS+ services are provided or billed by a provider. Service-level guidance is provided below for any potential retroactive payment of services rendered prior to obtaining an authorization, if applicable.

- CIS+ providers must submit clean claims to the member's health plan, meaning that the claim contains no errors, omissions, or discrepancies, and is submitted in the proper
- format with all necessary patient and service information, correct codes, and required supporting documentation, as applicable, to enable timely reimbursement for services rendered.
- Payment for other housing or housing-related supports that fall outside of those listed in Appendix A – Responsibilities is not allowed as a CIS+/Medicaid benefit.
- CIS+ providers must be contracted by the health plan to bill and receive payment for providing CIS+ services (see CIS+ Provider Medicaid Registration, and Qualifications of CIS+ Providers & Contracting Requirements for additional detail).

Services shall be billed to the health plan using one of the HCPCS codes provided in Table 5 below. The table describes the HCPCS codes to be used for billing and encounter data submission purposes, along with rates of reimbursement if paid by MQD on a FFS basis. Health plans will be reimbursed by MQD based on encounter data submitted using the approved HCPCS codes.

Table 5: CIS+ Service Categories and HCPCS Codes

Service Category	Service Description	HCPCS Code	Proposed Rate
CIS+ Engagement			
Engagement (pre-consent)	• Engagement • Obtain member CIS	T1023	QI: One bundled payment $200 per member per month CCS: One bundled payment $50 per member per month
Housing Navigation ~~CIS~~ Support (after CIS+ Consent Form is completed)			
Pre-tenancy Supports OR Tenancy Sustaining Services	• Transition, collaboration, and documentation • CIS+ Assessment • CIS+ Action Plan (PCSP) • Pre-tenancy supports • Tenancy sustaining services	H0044	QI & CCS: One bundled payment $350 per member per month
Medical Respite			
Short-term Pre-procedure housing	**Pre-procedure benefit usage** • Housing and support for members with a planned medical procedure requiring preparatory care	S5151 with Modifier SC	QI & CCS: $274 per member per day

	Post-procedure benefit usage • Housing and support for members with a planned medical procedure requiring care following treatment	S5151 with Modifier SE	QI & CCS: $274 per member per day
Short-term Recuperative Care	• Housing and clinically oriented support for members with ongoing medical and psychiatric needs	S9125 with modifier 22	QI & CCS: $274 per member per day
Short-term Post-hospitalization Housing	• Housing and limited support for members in continued recovery from a physical, psychiatric, or substance use condition following discharge or exit from an institution	S9125 with modifier SC	QI & CCS: $274 per member per day

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

15. <u>Housing Navigation Supports Billing Detail</u>

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

CIS+ providers registered with Medicaid may then bill the health plan (or the CCS health plan if the member is a CCS member) using their 6-digit Med-QUEST Provider ID. Submission of clean claim to health plan shall result in a per-member-per-month (PMPM) bundled payment to the provider. Housing navigation support providers are limited to one monthly bundled payment per member for either the engagement services category or the housing navigation supports category (pre-tenancy supports/tenancy sustaining services). Payments will reflect the full PMPM amount and will not be prorated. Claims payment shall align with standard claims payment timeframes.

Health 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.

Prior authorization turnaround times shall align with standard authorization turnaround times outlined in Contract RFP-MQD-2021-008, Section 5.2.B. To minimize the risk of delay in member service and provider payment, prior authorization for initial engagement (T1023) and future pre-tenancy supports/tenancy sustaining services (H0044) should be issued at the same time. Payment for future pre-tenancy supports/tenancy sustaining services (H0044) is contingent on CIS+ member consent and eligibility confirmation. Prior authorization for medical respite services should be completed as soon as possible to avoid delays in care.

Reporting Reference

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

Monthly Engagement Services

Health plans will authorize PMPM CIS+ engagement, screening and/or eligibility activities in a minimum of one month increments. It is generally expected that engagement will not extend beyond three months; however, it remains at the discretion of health plan to determine appropriate duration. Provider's engagement 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 Housing Navigation Supports (Pre-Tenancy Supports/Tenancy Sustaining Services)

Health plans will authorize PMPM CIS+ supports (pre-tenancy and tenancy) services in three 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 supports and tenancy sustaining services listed in Appendix A – Responsibilities. 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. If a CIS+ provider seeks to

discharge a member from their care, that provider should continue delivery of authorized services until another provider accepts the member and receives authorization from the health plan or until the current authorization expires, whichever is sooner.

Place of Service Coding

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

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

Housing navigation supports rendered via telehealth shall be billed as outlined in memorandum QI-2139.

16. <u>Medical Respite Billing Detail</u>

Medical respite services are reimbursed on a per diem bundled rate that covers all services described in <u>Appendix A – Responsibilities</u>, including transportation. Details on reimbursement for each of the three medical respite services are provided below.

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

Claiming detail:

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

If a CIS+ medical respite provider seeks to discharge a member from their care prior to completion of the authorized service, that provider should continue delivery of authorized services until another provider accepts the member and receives authorization from the health plan or until the current authorization expires, whichever is sooner.

If a member leaves a medical respite facility but wishes to return during the period originally authorized by the health plan, they may do so. For example, if the health plan authorized 30 days of short-term post-hospitalization housing, the member could leave after 10 days then return on day 20 of the authorization period to receive the last 10 days of the benefit, since this is still within the authorized one-month period. MQD recognizes that there may be operational barriers to members receiving services again, for example, the medical respite facility may not have a bed available. If a bed is unavailable at the original medical respite facility, the health plan may attempt to find placement for the member in another medical respite facility. Once the authorization period ends, the member is no longer eligible to return to medical respite.

Medical Respite Service Duration Limits

The health plan shall only authorize a combined total of six (6) months of medical respite services in a rolling 12-month period. Additional service-specific duration limits apply.

Per-diem Short-Term Pre-Procedure Housing

Health plans will authorize Short-term Pre-Procedure Housing for clinically appropriate durations, based on the information provided by a qualified health professional in the Medical Respite Authorization Form and follow-up communication. Short-term Pre-procedure Housing stays will be authorized before a planned medical procedure or treatment for no more than seven days, and for no more than three days for related post-procedure or post-treatment stays. While the service is named “short-term pre-procedure housing,” pre-procedure and post-procedure housing use different HCPCS code modifiers. For services provided before the planned procedure or treatment, medical respite providers may bill the member’s health plan using HCPCS code S5151 with modifier SC. For services provided after the planned procedure or treatment, medical respite providers may bill using HCPCS code S5151 with modifier SE.

Per-diem Short-Term Recuperative Care

Health plans will authorize per diem Short-term Recuperative Care services for clinically appropriate durations, based on the information provided by a qualified health professional in the Medical Respite Authorization Form and follow-up communication. Health Plans will authorize between seven and 90 days of Short-term Recuperative Care at a time. Members may receive no more than 90 days of continuous Short-term Recuperative Care. After services are provided, medical respite providers may bill the member's health plan using HCPCS code S9125 with modifier 22.

Per-diem Short-Term Post-hospitalization Housing

Health plans will authorize per diem Short-term Post-hospitalization Housing for clinically appropriate durations, based on the information provided by a qualified health professional in the Medical Respite Authorization Form and follow-up communication. Health plans will authorize, at a minimum, seven days of Short-term Post-Hospitalization Housing. After services are provided, medical respite providers may bill the member's health plan using HCPCS code S9125 with modifier SC.

17. Non-Medical Transportation (NMT) Billing Detail

Guidance on non-medical transportation will be published at a later date.

Payment for transportation, including non-medical transportation, is included in the medical respite rate. See Transportation section for more details on transportation responsibilities.

Reporting

18. Reporting

Health plan and CIS+ provider data will be used for required CMS reporting and for evaluating the QUEST Integration Section 1115 Demonstration.

MQD plans to release a new quarterly report to track medical respite data on January 1, 2026. Reporting expectations will occur in phases to provide health plans with adequate time to adapt and meet the new reporting requirements. Health plans should retain records of all required documentation, e.g., Medical Respite Authorization Form, CIS+ Consent Form, CIS+ Assessment, and CIS+ Action Plan. For medical respite services, MQD anticipates developing reporting requirements on the following:

- Eligibility
- Member progress through the CIS+ program and service timeliness
- Service authorization
- Service delivery
- Discharge location
- Other considerations

Health plans are responsible for accurate and timely reporting of the CIS+ program and its beneficiaries. Health plans should refer to the Health Plan Manual – Part III Reporting Guide, for the most recent version of the CIS+ reports and reporting requirements. As always, plans should monitor the Health Plan Manual updates on a quarterly basis. The CIS report will continue to be due quarterly, on the following schedule: January 31, April 30, July 31, and October 31.

~~Health plans are responsible for accurate and timely reporting of the CIS program and its beneficiaries. Health plans should refer to the Health Plan Manual – Part III Reporting Guide 23.4 released October 1, 2023, for the most recent version of the CIS reports and reporting requirements. As always, plans should monitor the Health Plan Manual updates on a quarterly basis.~~

MQD Learning Communities

19. 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 new CIS+ services.

If indicated by MQD, 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.

Provider Requirements

20. CIS+ Provider Medicaid Registration

Hawaii's Online Kahu Utility (HOKU) Medicaid registration is one step in the process to deliver CIS+ services. Registered Medicaid providers must also contract with health plans, which are

required to ensure that providers meet additional requirements (see Qualifications of CIS+ Providers & Contracting Requirements section for more details).

Housing Navigation Supports Provider Medicaid Registration Requirements

Any new housing navigation support provider delivering CIS+ services must register with Hawaii's Online Kahu Utility (HOKU) under the A3 provider type. As part of HOKU enrollment, new providers must submit a confirmation letter from Partners in Care (PIC - Oahu) or Bridging the Gap (BTG – Neighbor Islands) indicating their participation in the homeless services network. Existing CIS+ providers must be registered in HOKU with a provider type A3 or 77.

Medical Respite Provider Medicaid Registration Requirements

CIS+ medical respite providers must also register with Hawaii's Online Kahu Utility (HOKU) under provider type A8 (Medical Respite). The HOKU requirements of provider type A8 closely align with the requirements of provider type A3, but with additional requirements to ensure medical respite capability.

To qualify, A8 providers must meet the following requirements:

1. Demonstrate the ability to deliver medical respite services through one of the following three options:
   a. *National Institute for Medical Respite Care (NIMRC) Certification:* of certification by NIMRC;
   b. *Documented Experience:* Evidence of providing medical respite services through public contracts (e.g., state, health plan, hospital, or city/county) for at least one (1) year; or
   c. *MQD Approval:* Approval following a site visit by MQD verifying compliance with the minimum standards for a NIMRC Level 1 Coordinated Care Model as assessed by MQD.
2. Submit a confirmation letter from Partners in Care (PIC - Oahu) or Bridging the Gap (BTG – Neighbor Islands) indicating their participation in the homeless services network.

The three options to demonstrate ability to deliver medical respite services outlined above are designed to encourage a wide provider network for medical respite implementation. In the future, MQD may consider limiting A8 providers to those with NIMRC certifications. As such, MQD strongly encourages medical respite facilities to pursue NIMRC certification.

See Service Settings for guidance on medical respite provider settings and Appendix A – Responsibilities for medical respite facility services standards.

21. Qualifications of CIS+ Providers & Contracting Requirements

Health plans shall enter into a provider contract with each of the CIS+ providers that will be billing for services described in the Authorization, Billing and 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 CIS+ services for Medicaid members, as described in Provider Network Adequacy section.

Requirements for all CIS+ Providers

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

CIS+ providers must:

1. Have knowledge of principles, methods, and procedures of housing services covered under the CIS+ program, or comparable services meant to support individuals in obtaining and maintaining stable housing.
2. Maintain sufficient hours of operation and staffing to serve the needs of CIS+ participants.
3. Demonstrate their capabilities and/or experience with providing at least one CIS+ service, as described in Appendix A – Responsibilities. Health plans must review providers' capabilities and/or experience for each service under CIS+. CIS+ providers may demonstrate these capabilities and/or experience through, for example:

    a. One or more years of demonstrated experience to provide the specified CIS+ service(s). In addition to direct service provision, demonstrated experience may also include community outreach, completing assessments, assisting members with applying for benefits, obtaining necessary documentation, and other relevant experience as determined by the health plans.
    b. Maintaining all necessary licenses, registrations, and certifications as required by applicable federal and state laws, and the health plans. All CIS+ providers should have relevant training for the CIS+ services they are providing, which may include specific training and education on common housing capabilities such as harm reduction, fair housing laws, and the Health Insurance Portability and Accountability Act (HIPAA).
    c. Other methods deemed appropriate by the health plan.
    d. Evidence of qualified service delivery and administrative staff, as determined at the health plan's discretion.

4. The ability to comply with applicable federal and state laws.
5. The capacity to provide culturally and linguistically appropriate service delivery by:

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

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

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

Annually, providers must complete training in:

- Trauma Informed Care;
- HIPAA;
- Fair Housing; and
- How to report and address Major Unusual Incidents/Adverse Events.

Housing Navigation Support Provider Additional Qualifications

The preferred qualifications for housing navigation supports providers are listed in **Table 6**.

Table 6: 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 engagement; locating individuals on the street; completing assessments on homeless individuals; finding short- and long-term housing; and/or assisting individuals to apply for documents, benefits, and housing.
Skills	Knowledge of principles, methods, and procedures of services included under 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.

Medical Respite Provider Additional Qualifications

In addition to the overall CIS+ provider requirements, health plans must ensure that medical respite providers are equipped to meet members' needs. Below is a list of facility and safety minimum qualifications that providers offering short-term pre-procedure housing, short-term recuperative care, and/or short-term post-hospitalization housing must meet. However, some members may need a higher level of service, and the health plan must ensure that the setting can meet the needed level of care.

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

Facility environmental and safety minimum qualifications:

- Follows regulations for the storage, handling, security, and disposal of patient medications as described in HRS § 328-119;
- Adheres to NIMRC Standards for medical respite facilities developed by the National Health Care for the Homeless Council; and

- Has written protocols on the following topics:
- Reporting adverse events using the Adverse Event Report (AER) Form described in memo QI-2513;
- Connecting members to physical and behavioral healthcare;
- Connecting members to other needed benefits; and
- Discharging individuals from medical respite, including a policy that members are given a minimum of 24 hours' notice prior to being discharged from the program (exceptions for administrative discharges as determined by admissions, discharge, and program safety policies).

22. <u>Service Settings</u>

Housing Navigation Supports Service Settings

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

Medical Respite Service Settings

A variety of settings may provide medical respite services, provided they are registered as A8 providers and contracted with health plans. These settings may include, but are not limited to:

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

Medical respite CANNOT be provided in the following settings:

- Congregate sleeping spaces
- Facilities that have been temporarily converted to shelters (e.g. gymnasiums or

convention centers)
- Facilities where sleeping spaces are not available to residents 24 hours a day
- Facilities without private sleeping space[4]

Medical respite must be provided within medical respite facilities that meet the requirements described in Appendix A – Responsibilities.

23. Provider Network Adequacy

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

- A description of the health plan's strategies to identify and contract with CIS+ providers, including outreach strategies to expand provider participation.
- A defined internal escalation pathway for urgent cases where service delays could jeopardize member health.
- Policies for communicating clearly with beneficiaries when alternative providers or arrangements are required.

24. 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

As an example of program integrity responsibilities, health plans must ensure that members do not receive more than a combined six (6) months of medical respite services in a rolling 12-month period.

25. Documentation

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

Housing Navigation Support Documentation

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

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

Medical Respite Documentation

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

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

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

26. CIS+ Member Rights

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

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

27. Transportation

Effective January 1, 2026, members enrolled in CIS+ may be eligible to receive certain transportation supports associated with CIS+ services. These supports include (1) Non-Medical Transportation (NMT), which health plans cover to help members travel to and from CIS+ services and activities identified within their PCSP, and (2) transportation that supports a member's health and health-related social needs while receiving medical respite services. This section outlines the parameters for transportation within CIS+, describes how responsibilities are divided between health plans and CIS+ providers, and clarifies guardrails governing transportation services. The entity responsible for providing transportation varies by CIS+ benefit, as outlined in Table 7.

NOTE: This section does not address or restate policies on transportation to Medicaid-covered medical services under the State Plan Non-Emergency Medical Transportation (NEMT) benefit; health plans remain responsible for meeting those requirements for all members, including those in CIS+.

Non-Medical Transportation (NMT) Services

Effective January 1, 2026, NMT is transportation provided to members enrolled in CIS+ to and from CIS+ services or to other related destinations, as authorized in the member's CIS+ PCSP. For example, housing navigation services where NMT might be provided include, but are not limited to:

- In-person PCSP meetings when such meetings take place outside of the home,
- Housing or tenancy-related legal services,
- Appointments to obtain identification or documentation needed to apply for or receive benefits and supports, such as appointments at the Division of Motor Vehicles or a Social Security Office,
- Social or peer support services, such as tenancy training or other relevant educational events, and
- Any other benefits, services, or destinations related to the provision of Housing Navigation Supports, as indicated in the member's PCSP.

NMT shall be provided in alignment with the federal technical specifications and safeguards required under 1915(c) waivers or under 1915(i) state plan authorities. Specifically, the health plan shall ensure that NMT is provided in alignment with the following applicable standards:

- NMT does not replace and may not substitute transportation required under 42 CFR §431.53, the transportation services under the State Plan (i.e., emergency medical transportation or NEMT). Transportation to access medical care must be billed under the State Plan, not as NMT authorized under the Section 1115 Demonstration.
- NMT for CIS+ services may only be provided to access CIS+ benefits, services, or other related destinations as indicated in the member's CIS+ PCSP.
- Wherever possible and as identified in the member's CIS+ PCSP, family, neighbors, friends, or other community agencies that can provide needed transportation should be used before NMT is provided.
- When costs for NMT are included in the provider rate for another waiver service (as is the case for medical respite), health plans must have mechanisms in place to prevent duplication of billing of the NMT service (e.g., a medical respite provider cannot be paid separately for a specific NMT ride because transportation is already included in the medical respite provider rate).
- Provision of NMT must ensure the following beneficiary safeguards:
    - The health plan must have adequate standards for provider participation,
    - The health plan must have safeguards in place to protect the health and welfare of members receiving services, and
    - The health plan must have assurances of financial accountability for funds expended.

See Non-Medical Transportation Billing Detail section for more details on how NMT is reimbursed.

Transportation within Medical Respite Services

Transportation is recognized as an important part of the model of care for medical respite; as such, costs associated with medical respite provider responsibilities for transportation are included as a component in the per diem rate. Medical respite providers are responsible for providing and/or coordinating transportation to and from needed health and health related services (e.g., pre-procedure labs, to obtain prescriptions or medical supplies, post-operative appointments, etc.) and social services (e.g., appointments related to CIS+ housing navigation supports). Examples of instances where transportation may be provided or coordinated include, but are not limited to:

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

When transportation needs exceed the medical respite provider's reasonable capacity or capabilities—for example, inter-island travel, specialized medical transport—the provider must work with the health plan to authorize and arrange the appropriate transportation benefit. To avoid duplicate payments for transportation services, medical respite providers may not separately bill health plans for NEMT or NMT services for transportation that is already covered under the medical respite per diem rate.

Table 7: Health Plan and CIS+ Provider Transportation Roles

CIS+ Service	Health Plan Role	CIS+ Provider Role
Housing Navigation Supports	When appropriate, provide NMT for travel to CIS+ services and activities as identified in the member's PCSP.	Support the member in requesting and scheduling NMT and refer the member to the health plan when additional support is needed.

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

28. <u>Disenrollment and Re-Enrollment</u>

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

Possible Disenrollment Reasons

The member:

- 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
- Mutually agrees with the health plan that CIS+ services are no longer needed.

Housing Navigation Supports Reporting Reference

To report a CIS+ eligible member in CIS+ status code of either H5, or H6, as being lost to follow up (CIS+ status code H7), MQD is requiring that at least three unsuccessful attempts to reach the member in the last three months be made by a health plan or their designee. To report a

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

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

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

Notice of Adverse Benefit Determination

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

If a re-evaluation is requested as a component of an appeal, the same CIS+ assessment tools previously used to evaluate the member in the initial assessment shall be used to conduct the CIS+ eligibility reassessment. The process for such an appeal must comply with the

requirements in 42 C.F.R. Subpart F for an adverse benefit determination. The health plan shall incorporate a protocol for how CIS+ appeals by providers and members shall be reviewed and addressed into its overall member and provider grievance and appeals processes. The NOA shall be mailed to the member and the CIS+ provider by the health plan, or hand-delivered to the member when possible.

Housing Navigation Supports Reporting Reference

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

Opt-Out

Members enrolled in CIS+ will have the option to opt-out of the CIS+ program at any time. This opt-out option shall only be initiated by the member. 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 enrolling again in the CIS+ program if the member meets eligibility criteria.

***Reporting* Reference**

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

Special Considerations

29. Special Considerations for CCS Members

Housing Navigation Supports Reporting Reference

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

For members receiving housing navigation supports, the QI health plan will change the member status code to HC prior to transitioning the member to CCS. Upon transition, the CCS plan will complete the member assessment process and assign the status code. If the QI health plan is unable to reach a potentially eligible member [i.e., status code H8 (CIS+ – Potentially Eligible Unable to Contact)], the QI health plan shall transition the information available on the member to the CCS plan so that the CCS plan is well-poised to re-attempt to contact the member in the future. If a member is already 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 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.

~~***Medical Respite CCS Considerations***~~

~~Both QI and CCS plans may administer the medical respite benefit. Whichever entity receives the referral will be responsible for responding to the request, determining eligibility, and administering the benefit for the initial authorization period. Once the member is receiving~~

~~medical respite, if the member has a CCS plan, the QI health plan should conduct a warm handoff and transition CIS+ benefit administration to the CCS plan.~~

30. Special Considerations for Referrals from Hospitals

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

Health plans shall work closely with hospital staff on proactive identification of members potentially eligible for CIS+ as well as early notification of an admission for members potentially eligible for CIS+ and are encouraged to utilize existing electronic notification protocols to assist with the referral process. Health plan staff shall screen the member to assess eligibility, obtain consent, organize appropriate follow up with the member, and engage a CIS+ provider as appropriate.

Housing Navigation Supports Reporting Reference

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

CIS+ Timeframes and Status Codes

31. CIS+ Activity Timeframes

Table 8 shows the maximum allowable timeframes for CIS+ activities related to housing navigation supports and medical respite. It also includes an example to illustrate housing navigation support deadlines.

Table 8: CIS+ Activity Timeframe

CIS+ Activity	Housing Navigation Supports Timeframe	Housing Navigation Supports example using maximum allowed times:	Medical Respite Timeframe
Internal Potential Eligible and New External Referrals	Up to 30 days to determine eligibility and authorize initial engagement and Pre-tenancy Supports/Tenancy Sustaining Services. To minimize service delay, encourage <15 days.	At risk individual referred to HP by family member on January 1, 2023. January 31, 2023, confirmed eligibility and pre-authorization for initial Engagement and Pre-tenancy/ Tenancy completed.	Health plan shall determine eligibility within seven days of receipt of the Medical Respite Authorization Form. If the member is being discharged from an institution in less than seven days, the health plan must determine eligibility before discharge.
CIS+ Member Consent	Encourage to obtain consent within 10 days after engagement authorized or initiated by HP. (May be extended based on member need)	February 10, 2023 – consent obtained.	Health plans must obtain consent within 10 days after eligibility is determined, or as soon as possible if the member is institutionalized or has an upcoming procedure.
PCSP	After consent is obtained, up to 45 days to complete CIS+ Assessment and CIS+ Action Plan.	March 27, 2023 – CIS+ Assessment and CIS+ Action Plan completed.	A PCSP must be established within three calendar days ~~72 hours~~ of medical respite facility admission.
	Submit all completed documents to HP within 30 days of completion.	April 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.	May 26, 2023 – CIS+ Assessment and CIS+ Action Plan data are available to submit in the next quarterly report	More detail forthcoming.

CIS+ Action Plan Update	CIS+ action plan to be reviewed/updated every 90 days.	June 27, 2023 – CIS+ Action Plan update due.	Not applicable.

32. <u>CIS+ Status Codes</u>

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

Table 9: CIS+ Status Codes

CIS+ Status Code	Description	Notes
H1	CIS+ – POTENTIALLY ELIGIBLE	Use this code for potentially eligible members who have been identified based on ICD codes or other evidence and engagement IS NOT authorized.
HA	CIS+ – POTENTIALLY ELIGIBLE WITH ENGAGEMENT AUTHORIZED	Use this code for potentially eligible members who have been identified based on ICD codes or other evidence and engagement IS authorized for housing navigation supports.
H2	CIS+ – CONFIRMED ELIGIBLE FOR HOUSING NAVIGATION SUPPORTS	Use this code for members eligible for housing navigation supports, not yet consented to participate in services.
H3	CIS+ – NOT ELIGIBLE FOR HOUSING NAVIGATION SUPPORTS	Use this code for members who do not meet requirements for housing navigation supports.
HC	CIS+ – ELIGIBLE CONSENTED	Use this code for eligible members, who have signed a consent to participate in the CIS+ program overall. The member is consider enrolled at this time.
H4	CIS+ – ELIGIBLE REFUSED	Use this code for eligible members, who refused to participate in the program.
H5	CIS+ – PRE-TENANCY SUPPORTS	Use this code for enrolled members receiving CIS+ Pre-Tenancy Supports.
H6	CIS+ – TENANCY SUSTAINING SERVICES	Use this code for enrolled members receiving CIS+ Tenancy Sustaining Services.

H7	CIS+ – ENROLLED LOST TO FOLLOW UP	Use this code for enrolled members who have been lost to follow up with three or more unsuccessful attempts by the health plan in the past three months.
H8	CIS+ – POTENTIALLY ELIGIBLE UNABLE TO CONTACT	Use this code for potentially eligible members (found eligible by health plan) who have been unable to contact with three or more unsuccessful attempts by the health plan in the past six (6) months.
HP	CIS+ – EXITED TO PERMANENT HOUSING	Use this code for enrolled members who have exited the program to a known exit destination of permanent housing or long-term institutional setting (e.g. nursing homes).
HT	CIS+ – EXITED TO TEMPORARY HOUSING	Use this code for enrolled members who have exited the program to a known exit destination of temporary housing (e.g. transitional housing, homeless shelter and emergency shelter) or short-term institutional settings (e.g. hospital, short-term rehab).
HH	CIS+ – EXITED BACK TO HOMELESSNESS	Use this code for enrolled members who have exited the program back to homelessness. (e.g. places not meant for habitation).
HM	CIS+ – EXITED OTHER/ MISCELLANEOUS	Use this code for enrolled who have exited the program due to all other reasons not defined above. (e.g. death, incarceration, loss of Medicaid coverage).

33. Appendices

Table 10: Appendices

Appendix	Status
Appendix A – Responsibilities	No change from QI-2314D
Appendix B – CIS+ Referral Form	No change from QI-2314D
Appendix C – CIS+ Consent Form	No change from QI-2314D
Appendix D – CIS+ Assessment	No change from QI-2314D
Appendix E – CIS+ Action Plan	No change from QI-2314D
Appendix H – CIS+ Process Flow	No change from QI-2314D
Appendix I – Medical Respite Authorization Form	No change from QI-2314D
Appendix J – Medical Respite Person Centered Service Plan	New

This document describes the benefits and responsibilities associated with Housing Navigation Supports and/or Medical Respite. Health plans have primary responsibility for the implementation of these activities, but may opt to delegate the activities defined below to their contracted providers. If a health plan chooses to delegate the identified activities to a contracted provider, MQD expects that implementation efforts between plans and providers are coordinated and collaborative.

CIS+ services will be furnished only to the extent it is reasonable and necessary as clearly identified through an enrollee's person-centered service plan, when the enrollee is eligible for the service, and when the services cannot be obtained from other sources. The CIS+ program is voluntary for members.

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

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

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

Medical Respite	
Short-term Pre Procedure Housing	i. Providing short-term housing prior to those who have a planned medical procedure requiring preparation care (e.g., colonoscopy) or who have a planned medical treatment requiring care prior to or following treatment (e.g., chemotherapy treatment). Housing requirements include: a. A private[1] sleeping space available to the Member 24 hours a day, b. Onsite showering and laundering facilities; c. Clean linens upon admission; d. Secured storage for personal belongings and medications; and e. At least three meals a day provided. ii. When applicable and appropriate, providing clinically oriented recuperative or rehabilitative services and supports. Services are only provided for a clinically appropriate period of time and may include but are not limited to: a. Offering medication support for Members who self-manage medication, or managing medication via licensed clinical staff in collaboration with the Member; b. Providing at least one wellness check every 24 hours (clinical or non-clinical staff); c. Providing access to non-emergency telemedicine or nurse line; d. Providing and/or coordinating transportation to and from needed health and health related services (e.g., pre-procedure labs, to obtain prescriptions or medical supplies, post operative appointments, etc.) and social services (e.g., appointments related to housing navigation supports). When transportation needs exceed what the provider can reasonably accommodate (e.g., inter-island travel or other extensive transportation requirements), the provider should coordinate with the Member's health plan to arrange and authorize transportation through covered non-emergency medical transportation (NEMT) or non-medical transportation (NMT) benefits; and e. Reporting incidents, Member concerns, and notable changes in the Member's condition to the Member's designated medical provider, other respite staff members working the oncoming shift, and other entities such as QI Health Plans, as appropriate. iii. When applicable and appropriate, collaborating with health plans to coordinate activities for physical health, behavioral health, and social needs. Such activities may include but are not limited to: a. Screening for unmet health or social needs;

[1] Includes appropriate semi-private settings, such as those with dividers for privacy

	b. Connecting the individual to community programs, such as substance use programs, and social benefits in collaboration with the health plan; c. Coordinating with relevant case management, Health Coordination, or care management entities, including the QI Health Plan, CCS behavioral health plan and/or the Housing Navigation Support provider; and d. Participating in person-centered plan meetings at CIS+ redetermination and/or revision plan meetings, as needed.
Short-term Recuperative Care	i. Providing up to 90 days of short-term residential care to support ongoing medical and psychiatric needs. Housing requirements include: a. A private[2] sleeping space available to the Member 24 hours a day, b. Onsite showering and laundering facilities; c. Clean linens upon admission; d. Secured storage for personal belongings and medications; and e. At least three meals a day provided with monitoring and supporting of nutrition and diet. ii. Providing clinically oriented recuperative or rehabilitative services and supports. Services may include but are not limited to: a. Providing basic medical clinical services onsite, including monitoring vital signs, conducting assessments, wound care, and other support services; b. Offering medication support for Members who self-manage medication, or managing medication via licensed clinical staff in collaboration with the Member; c. Ongoing monitoring of the member's condition by clinicians; d. Providing at least one wellness check every 24 hours (clinical or non-clinical staff); e. Providing access to non-emergency telemedicine or nurse line; f. Providing and/or coordinating transportation to and from needed health and health related services (e.g., pre-procedure labs, to obtain prescriptions or medical supplies, post operative appointments, etc.) and social services (e.g., appointments related to housing navigation supports). When transportation needs exceed what the provider can reasonably accommodate (e.g., inter-island travel or other extensive transportation requirements), the provider should coordinate with the Member's health plan to arrange and authorize transportation through covered non-emergency medical transportation (NEMT) or non-medical transportation (NMT) benefits; and

[2] Includes appropriate semi-private settings, such as those with dividers for privacy

	g. Reporting incidents, Member concerns, and notable changes in the Member's condition to the Member's designated medical provider, other respite staff members working the oncoming shift, and other entities such as QI Health Plans, as appropriate. iii. When applicable and appropriate, supporting collaborating with health plans to coordinate activities for physical health, behavioral health, and social needs. Such activities may include but are not limited to: a. Screening for unmet health or social needs; b. Connecting the individual to community programs, such as substance use programs, and social benefits, in collaboration with the health plan; c. Coordinating with relevant case management, Health Coordination, or care management entities, including the QI Health Plan, CCS behavioral health plan and/or the Housing Navigation Support provider; and d. Participating in person-centered plan meetings at CIS+ redetermination and/or revision plan meetings, as needed.
Short-term Post-Hospitalization Housing	i. Providing up to six months of short-term housing for individuals who do not have a residence to continue recovery for physical, psychiatric, or substance use conditions following discharge or exit from an institution. Housing requirements include: a. A private[3] sleeping space available to the Member 24 hours a day, b. Onsite showering and laundering facilities; c. Clean linens upon admission; d. Secured storage for personal belongings and medications; and e. At least three meals a day provided with monitoring and supporting of nutrition and diet. ii. Providing clinically oriented recuperative or rehabilitative services and supports. Services may include but are not limited to: a. Offering medication support for Members who self-manage medication, or managing medication via licensed clinical staff in collaboration with the Member; b. Providing at least one wellness check every 24 hours (clinical or non-clinical staff); c. Providing access to non-emergency telemedicine or nurse line; d. Providing and/or coordinating transportation to and from needed health and health related services (e.g., pre-procedure labs, to obtain prescriptions or medical supplies, post operative appointments, etc.) and social services (e.g.,

[3] Includes appropriate semi-private settings, such as those with dividers for privacy

	appointments related to housing navigation supports). When transportation needs exceed what the provider can reasonably accommodate (e.g., inter-island travel or other extensive transportation requirements), the provider should coordinate with the Member's health plan to arrange and authorize transportation through covered non-emergency medical transportation (NEMT) or non-medical transportation (NMT) benefits; and e. Reporting incidents, Member concerns, and notable changes in the Member's condition to the Member's designated medical provider, other respite staff members working the oncoming shift, and other entities such as QI Health Plans, as appropriate. iii. When applicable and appropriate, in collaboration with the health plan to coordinate activities for physical health, behavioral health, and social needs. Such activities may include but are not limited to: a. Screening for unmet health or social needs; b. Connecting the individual to community programs, such as substance use programs, and social benefits, in collaboration with the health plan; c. Coordinating with relevant case management, Health Coordination, or care management entities, including the QI Health Plan, CCS behavioral health plan and/or the Housing Navigation Support provider; and d. Participating in person-centered plan meetings at CIS+ redetermination and/or revision plan meetings, as needed.

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Community Integration Services Plus (CIS+) – Referral

(Appendix B)

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 Facility	☐ Social/Housing Services Provider
☐ Hospital	☐ 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: SERVICES NEEDED	
8. What service(s) does the member need? (Subject to eligibility and member consent)	
Housing Navigation Supports (HNS): ☐ Pre-Tenancy Supports ☐ Tenancy Sustaining Services	*Medical Respite (MR):* ☐ Short-term Pre-Procedure Housing ☐ Short-term Recuperative Care ☐ Short-Term Post-Hospitalization Housing

PART 3: MEMBER INFORMATION		
9. Member First Name:	10. Member Last Name:	11. MI:
12. Date of Birth: _____/_____/_____	13. Member HMIS #:	14. Medicaid ID #:
15. CCS? ☐ No ☐ Yes	16. Health Plan: ☐ HMSA ☐ Kaiser ☐ AlohaCare ☐ Ohana ☐ United	
17. Current Location/Address:	18. City, State, Zip Code:	
19. Mailing Address (if different from above):	20. City, State, Zip Code:	
21. Best Contact Phone Number:	22. Best Contact Email Address:	
23. Any friends or family who can help reach member? ☐ No ☐ Yes, Name/Phone:		
24. Does the member have interpretation needs? ☐ No ☐ Yes, Language:		

PART 4: PRESUMPTIVE MEMBER ELIGIBILITY INFORMATION (Subject to Verification)	
A member is eligible for CIS+ if they have <u>both</u> a housing risk factor and either a health or medical respite need. **ATTACH EVIDENCE OF CHECKED OFF HEALTH NEEDS and RISK FACTORS if known**	
PART A: HEALTH NEEDS-BASED CRITERIA	**PART B: HOUSING CRITERIA**
☐ Mental Health ☐ Complex Physical Health ☐ Substance Use	☐ Homelessness, if checked (☐ Sheltered/☐ Unsheltered) ☐ At risk of homelessness
PART C: MEDICAL RESPITE (IF APPLICABLE) (Include Medical Respite Authorization Form if medical provider)	
☐ At risk of hospitalization, institutionalization, or emergency department utilization ☐ In an institution (e.g., inpatient hospital, nursing facility) ☐ Have a planned medical procedure requiring care prior to or following the procedure	

CIS+ Referral Form Instructions

Please fax this referral to the appropriate Health Plan with ATTN: QI CIS+ Program

AlohaCare Fax	**HMSA** Fax	**Kaiser** Fax	**Ohana** Fax	**United** Fax	**CCS** Fax
HNS/MR: 808-973-0676	HNS/MR: 808-948-8243	HNS/MR: 855-416-0995	HNS: 855-703-8078 MR: 855-637-2941	HNS/MR: 800-267-8328	HNS: 855-703-8078 MR: 855-637-2941

If you do not know the member's Health Plan, please fax to Med-QUEST at 808-692-8087.

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Community Integration Services Plus (CIS+) – Consent

(Appendix C)

First Name	Last Name	DOB	Preferred Name:	Medicaid ID #

Consent to participate in Community Integration Services Plus CIS+ (Member must check all boxes):

The following has been explained to me:

☐ Medical respite services. I understand that these services are limited to a maximum of six (6) months in a year.

☐ Housing navigation supports. I understand that these services may be available for limited periods of time.

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 Plus**

☐ REFUSE: I do not want **Community Integration Services Plus**

REASON FOR REFUSAL: _____

By signing below, I understand and agree to the following:

☐ I will take part in CIS+ visits and assessments.

☐ My health plan will approve CIS+ benefits for limited periods of time, based on my needs.

☐ I can choose which CIS+ services I want to receive.

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

_____ _____

Member or Advocate/Representative Signature **Date**

If signed by Member Advocate/ Representative,

Relationship to Member: _____ Phone Number: _____

For CIS+ Services Agency, Health Plan, or Delegate Use Only

☐ I attest that I have explained all of the available CIS+ services that the member may be eligible for and the benefit limits. The member had the opportunity to ask questions and provided consent freely.

_____ _____

CIS+ Services Agency, Health Plan, or Delegate Name **Staff Name and Title**

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Community Integration Services Plus (CIS+) – Assessment

(Initial/Re-enrollment – Appendix D)

Part I: Agency Information

CIS+ Provider Agency:	Medicaid 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:	
	1.	Yes ☐ No ☐		
	2.	Yes ☐ No ☐		
Any friends or family who can help reach you? Yes ☐ No ☐ If yes, Contact Name:			Contact Phone Number:	Relationship to Member:

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Community Integration Services Plus (CIS+) – Assessment

(Initial/Re-enrollment – Appendix D)

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 _____	Does participant require a live in caregiver? □ Yes □ No	Does participant want a roommate? □ Yes □ No □ Maybe

Homeless Status	Medical Respite Need
□ 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)*	Participant has a clinical need for: □ Short-term pre-procedure housing □ Short-term recuperative care □ Short-term post-hospitalization housing □ No medical respite need

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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Community Integration Services Plus (CIS+) – Assessment

(Initial/Re-enrollment – Appendix D)

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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Community Integration Services Plus (CIS+) – Assessment

(Initial/Re-enrollment – Appendix D)

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 □ Medical Respite (i.e. clinically supportive living environment)
How many bedrooms does the participant want (excludes medical respite)? □ 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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Community Integration Services Plus (CIS+) - Action Plan
(Appendix E)

Part I: Agency Information

CIS+ Provider Agency:	Medicaid 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:	
	1.	Yes ☐ No ☐		
	2.	Yes ☐ No ☐		
Any friends or family who can help reach you? Yes ☐ No ☐ If yes, Contact Name:			Contact Phone Number:	Relationship to Member:

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Community Integration Services Plus (CIS+) - Action Plan
(Appendix E)

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. You do not have to answer a question if you don't want 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) _____ days	at an emergency shelter _____ days	at a temp/transitional shelter _____ days	in a supervised group home _____ days	in a shared apartment _____ days	in an independent apartment _____ 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**: 7a. What type of housing: ☐ Permanent ☐ Temporary/Transitional ☐ Institutional ☐ Other 7b. Are you newly housed since the last assessment: ☐ Yes ☐ No			☐ No. If **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?			

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Community Integration Services Plus (CIS+) - Action Plan
(Appendix E)

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. CIS+ short-term pre-procedure housing (for a planned procedure/treatment)	☐	☐	☐
7. CIS+ short-term recuperative care (up to 90 days)	☐	☐	☐
8. CIS+ short-term post-hospitalization housing (up to 6 months)	☐	☐	☐
9. Emergency shelter/temp housing/transitional housing	☐	☐	☐
10. Permanent housing	☐	☐	☐
11. Landlord mediation	☐	☐	☐
12. Development of/changes to eviction prevention plan	☐	☐	☐
13. Ongoing housing subsides	☐	☐	☐
Healthcare			
14. Accessing medical services; vision; nutrition/dietitian, dental; primary care	☐	☐	☐
15. Accessing mental health services and social supports; crisis services	☐	☐	☐
16. Substance abuse treatment services	☐	☐	☐
17. Compliance with Medical/Mental Health/Substance Use Plan of Care and medications	☐	☐	☐
Health Coordination			
18. Health Coordination by Health Plan *If member needs or refuses health coordination, refer to health plan for review*	☐	☐	☐

Community Integration Services Plus (CIS+) - Action Plan
(Appendix E)

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

Part VI: Person-Centered Housing Goals

32. 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

Community Integration Services Plus (CIS+) - Action Plan
(Appendix E)

Part VII: Other Interviewer Notes and Observations:

33. Person-centered plan meeting or revision plan meeting held with member: ☐ Yes ☐ No
34. CIS+ assessment completed: ☐ Yes ☐ No
35. Notes:

Part VIII: Discharge from CIS+:

36. 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

Detailed CIS+ Process

Identifying Beneficiaries

HP identifies potentially eligible beneficiary

HP receives CIS+ Referral Form through fax

HP receives self/community referrals through other communication channels

HP updates CIS+ Status Code to (H1)

Key

Decision

Action

Service Receipt

Service End

QI HP – QI Health Plan
CCS – Community Care Services Program for Behavioral Health
HP – Any Medicaid HP, QI or CCS

Determining Eligibility

Based on referral information, HP completes eligibility screening

Member needs Housing Navigation Supports only

Member needs Medical Respite only

Member needs Medical Respite and Housing Navigation Supports

Scenario 1: HP has sufficient information to determine eligibility

Scenario 2: Member engagement is needed; HP meets with Member to complete eligibility screening

Scenario 3: Provider engagement is needed; HP authorizes 1-3 months of provider engagement (T1023) and updates CIS+ Status Code to (HA)

Provider meets with Member to determine eligibility

Scenario 4: HP checks eligibility for **short-term recuperative care.** A qualified health professional must submit a Medical Respite Authorization Form.

Scenario 5: HP checks eligibility for **short-term post-hospitalization housing.** A qualified health professional must submit a Medical Respite Authorization Form.

Scenario 6: HP checks for eligibility for **short-term pre-procedure housing** and (optional) verifies complex behavioral/physical need for housing navigation supports eligibility. A qualified health professional must submit a Medical Respite Authorization Form.

HP makes eligibility determination

HP makes eligibility determination

HP makes eligibility determination

Result 3: Potentially eligible but unable to contact (after 3 attempts to contact in the past 6 months).

For members receiving housing navigation supports, HP updates CIS+ Status Code to (H8)

HP sends Notice of Adverse Benefit Determination

Result 5: Not eligible for pre-procedure housing

Result 4: Eligible for Housing Navigation Services only, not short-term pre-procedure housing

Result 1: Confirmed eligible for Housing Navigation Supports

HP updates CIS+ Status Code to (H2)

Result 2: Not eligible

HP updates CIS+ Status Code to (H3)

Result 1: Not eligible for short-term recuperative care or short-term post-hospitalization housing.

Result 2: Member has both:
1) short-term recuperative care *or* short-term post-hospitalization housing need and;
2) housing related need

Result 1: Member has all three needs:
1) pre-procedure housing need,
2) housing related need, and;
3) complex behavioral/ physical health need

Result 2: Member has:
1) pre-procedure housing need,
2) housing related need, but
3) *NO* confirmed complex behavioral/ physical health need

HP solicits consent using the CIS+ Member Consent form and conducts person-centered service planning.

Member does not sign form

HP updates CIS+ Status Code to eligible refused (H4)

Member does not sign form

HP solicits consent using the CIS+ Member Consent form and conducts person-centered service planning

Member signs form

HP updates CIS+ Status Code to eligible consented, (HC)

Member signs form, wants Housing Navigation Supports only

Member signs form, wants Medical Respite

Coordinating Services

Does the Member have a CCS plan?

Yes

No

For Members in CCS plans, QI HP conducts warm handoff to the CCS plan

HP authorizes Pre-Tenancy Supports or Tenancy Sustaining Services for up to 3-months at a time and engages a provider

Provider conducts CIS+ Assessment and HP updates CIS+ Status Code to:
1. Pre-Tenancy Supports (H5)
2. Tenancy Sustaining Services (H6)

If there are other needs identified (e.g. LTSS), HP to arrange additional assessment

If Member wants to health coordination, HP to complete Health and Functional Assessment (HFA) and Health Action Plan (HAP)

Provider, in partnership with Member, develops or updates CIS+ Action Plan (initial, quarterly, and discharge)

Provider delivers additional pre-tenancy support (H0044)

Provider delivers additional tenancy sustaining services (H0044)

If the Member is eligible the member can begin receiving pre-tenancy and tenancy sustaining supports, while receiving medical respite

HP authorizes specified days of medical respite

HP engages provider for medical respite services:
1. Pre-procedure housing
2. Recuperative care
3. Post-hospitalization housing

Provider delivers **medical respite** services
1. Short-term pre-procedure housing (S5151 with modifier SC)
2. Recuperative care (S9125 with modifier 22)
3. Short-term post-hospitalization housing (S9125 with modifier SC)

Authorized medical respite period ends

HP engages Member to discuss other CIS+ benefits, or connections to other services (other CIS+ services can be delivered alongside medical respite services)

Member does not need or desire other benefits

Claiming and Payment

Provider submits claim to HP

HP processes and pays CIS+ claim

HP auditing

HP submits encounter data to MQD through Hawaii Prepaid Medical Management Information System (HPMMIS)

Service End: Benefit authorization expires, or member elects to end participation

HP updates CIS+ Status Code based on Member status at end of program:
1. Enrolled, lost to follow up, (H7)
2. Exited to permanent housing, (HP)
3. Exited to temporary housing, (HT)
4. Exited back to homelessness, (HH)
5. Exited other (e.g. death, incarceration, loss of Medicaid coverage), (HM)

If service end is involuntary HP sends Notice of Adverse Benefit Determination

CIS+ Status Code	Description
H1	POTENTIALLY ELIGIBLE
HA	POTENTIALLY ELIGIBLE WITH ENGAGEMENT AUTHORIZED
H2	CONFIRMED ELIGIBLE FOR HOUSING NAVIGATION SUPPORTS
H3	NOT ELIGIBLE FOR HOUSING NAVIGATION SUPPORTS
HC	ELIGIBLE CONSENTED
H4	ELIGIBLE REFUSED
H5	PRE-TENANCY SUPPORTS
H6	TENANCY SUSTAINING SERVICES
H7	ENROLLED LOST TO FOLLOW UP
H8	POTENTIALLY ELIGIBLE UNABLE TO CONTACT
HP	EXITED TO PERMANENT HOUSING
HT	EXITED TO TEMPORARY HOUSING
HH	EXITED BACK TO HOMELESSNESS
HM	EXITED OTHER/ MISCELLANEOUS

Med-QUEST, DHS

Community Integration Services Plus (CIS+)
Medical Respite Authorization Form (Appendix – I)

This referral form should be shared with the Medicaid member's QI Health Plan (see plan contact information at the end of this form). If medical respite is authorized, the QI Health Plan may share information from this authorization form with medical respite facilities to coordinate service provision.

A clinician must review, approve, and sign the medical respite authorization form for health plans to determine member eligibility and authorize CIS+ benefits. Signing clinicians must be a Doctor of Medicine (MD), Doctor of Osteopathic Medicine (DO), Nurse Practitioner (NP), or Physician Assistant (PA).

<table>
<tr><th colspan="6">PART 1: CLINICIAN REFERRAL SOURCE AND DIRECTION</th></tr>
<tr><td colspan="3">Signing Clinician Information</td><td colspan="3">Coordinator, if different from the signing clinician</td></tr>
<tr><td colspan="3">Clinician Name:</td><td colspan="3">Coordinator Name:</td></tr>
<tr><td colspan="3">Clinician NPI:</td><td colspan="3">Coordinator Email:</td></tr>
<tr><td colspan="3">Clinician Relationship to Member:</td><td colspan="3" rowspan="3">Coordinator Phone Number:</td></tr>
<tr><td colspan="3">Clinician Phone Number:</td></tr>
<tr><td colspan="3">Clinician Email:</td></tr>
<tr><th colspan="6">PART 2: MEMBER INFORMATION</th></tr>
<tr><td colspan="2">First Name:</td><td colspan="2">Last Name:</td><td colspan="2">MI:</td></tr>
<tr><td colspan="2">Date of Birth:</td><td colspan="2">HMIS#, if known:</td><td colspan="2">Medicaid ID #:</td></tr>
<tr><td>CCS?
☐ No ☐ Yes</td><td colspan="2">Gender
☐ Male ☐ Female ☐ Non-binary
☐ Prefer not to respond</td><td>Veteran?
☐ No ☐ Yes</td><td>Height:</td><td>Weight:</td></tr>
<tr><td colspan="3">Current Location/Address:</td><td colspan="3">City, State, Zip Code:</td></tr>
<tr><td colspan="3">Mailing Address (if available and different from above):</td><td colspan="3">City, State, Zip Code:</td></tr>
<tr><td colspan="3">Best Contact Phone Number:</td><td colspan="3">Best Contact Email Address:</td></tr>
<tr><td colspan="6">Any friends or family who can help reach the member?
☐ No ☐ Yes, Name/Phone:</td></tr>
<tr><td colspan="6">Does the member have interpretation needs?
☐ No ☐ Yes, Language:</td></tr>
<tr><th colspan="6">PART 3: SERVICES NEEDED</th></tr>
<tr><td colspan="6">Diagnosis(es):</td></tr>
</table>

What medical respite service do you recommend for the member?

☐ Short-term Pre-Procedure Housing: For members in need of housing who have a planned medical procedure requiring preparatory care or a medical treatment requiring care prior to or following treatment. The maximum service length is determined by clinical appropriateness, not to exceed six (6) months of medical respite benefits per rolling 12-month period. Post-procedure treatment is limited to three (3) days.
Date of procedure and reason for procedure: _____.

☐ Short-term Recuperative Care: For members in need of housing with clinically oriented recuperative or rehabilitative services or supports, and monitoring of ongoing medical and/or psychiatric needs. The maximum service length is determined by clinical appropriateness, not to exceed 90 days or six (6) months of medical respite benefits per rolling 12-month period.
Date of hospital admission and reason for admission: _____.

☐ Short-Term Post-Hospitalization Housing: For members in need of housing and limited support to continue recovery from a physical, psychiatric, and/or substance use condition, often following discharge or exit from an institution. The maximum service length is determined by clinical appropriateness, not to exceed six (6) months of medical respite benefits per rolling 12-month period.
Date of hospital admission and reason for admission: _____.

Recommended medical respite length of stay: _____.

Which clinical eligibility criteria does the member meet (check all that apply):

☐ Has a planned medical procedure requiring preparation care (e.g., colonoscopy) or have a planned medical treatment (e.g., chemotherapy treatment) requiring care prior to or following treatment.
Required for Short-term Pre-Procedure Housing.

☐ In institutional care, which may include an acute care hospital, state mental health hospital, nursing facility, or other inpatient or institutional setting (institutional settings do not include the emergency department).
Required for Short-term Recuperative Care and Short-term Post-Hospitalization Housing.

☐ Has an ongoing physical and/or behavioral health need that would otherwise require continued institutional care if not for receipt of medical respite.
Required for Short-term Recuperative Care and Short-term Post-Hospitalization Housing.

Please attach evidence of checked eligibility criteria, if known (e.g., clinical justification).

Which social eligibility criteria does the member meet?

☐ Homeless ☐ At risk of homelessness ☐ Other, please describe:

Please attach evidence of homelessness, or risk of homelessness, if known.

Does the member also need housing navigation support?

☐ No ☐ Yes

PART 4: MEDICAL CONDITION

Member had a Positive Purified Protein Derivative (PPD) test?	Member had a chest X-ray?
☐ No ☐ Yes Date PPD read:	☐ No ☐ Yes If yes, Chest X-ray Date: If yes, Chest x-ray: ☐ Positive ☐ Negative

Is medical follow-up required for the member?

☐ No ☐ Yes If yes, please describe:

Is the member able to self-administer and monitor own medication?

☐ No ☐ Yes

Does the member adhere to all aspects of medical care?

☐ No If no, please describe:

☐ Yes

Does the member have an intact immune system?

☒ No If no, please describe:

☐ Yes

Does member have a history of known communicable diseases?

☐ No ☐ Yes, if yes, list and include date of last episode:

Does the member have other external appliances (durable medical equipment or medical devices)?

☐ No ☐ Yes

Does the member have special diet requirements?

☐ No ☐ Yes, if yes, list:

Does the member have any medication allergies?

☐ No ☐ Yes, if yes, list:

Are vaccination records available for this member?

☐ No ☐ Yes

Please list current medications:

Other comments:

PART 5: BEHAVIORAL HEALTH / CHEMICAL DEPENDENCY STATUS

Is member alert and oriented to time and place?

☐ No ☐ Yes

Does the member have memory loss?

☐ None ☐ Short-term ☐ Long-term ☐ Both

Mental health history:

If applicable, mental health case manager name and contact information:

Does the member have a history of violent behavior?

☐ No ☐ Yes, please describe with reason and include date of last episode:

Does the member have a history of suicidal behavior?

☐ No ☐ Yes, describe and include date of last episode:

Does the member have a history of substance abuse/chemical dependency? ☐ No ☐ Yes, list substance(s) and last use: Preferred substance: Interested in treatment?: ☐ No ☐ Yes
Drug screen results? ☐ Positive, Date of test:_____ ☐ Negative, Date of test: _____ ☐ Drug screening not complete
History of smoking? ☐ No ☐ Yes
History of Traumatic Brain Injury (TBI)? ☐ No ☐ Yes, if yes describe:

PART 6: MEMBER'S ABILITY TO PERFORM ACTIVITIES OF DAILY LIVING (ADLs) WITHOUT ASSISTANCE	
Able to walk at least 30 feet? ☐ No ☐ Yes	Able to prep simple meals independently? ☐ No ☐ Yes
Able to navigate stairs? ☐ No ☐ Yes	Able to feed self? ☐ No ☐ Yes
Uses ambulatory aids? ☐ No ☐ Yes If yes, describe: If yes, able to transfer independently? ☐ No ☐ Yes	Continent of: Bowel: ☐ No ☐ Yes Bladder: ☐ No ☐ Yes Able to toilet self? ☐ No ☐ Yes
Able to maintain good hygiene? ☐ No ☐ Yes	Able to bathe self? ☐ No ☐ Yes
Any communication barrier (e.g. language, hard of hearing)? ☐ No ☐ Yes, if yes, describe:	

Clinician Signature: _____

Date: _____

CIS+ Medical Respite Authorization Instructions

Please fax this document to the member's Health Plan with ATTN: Medical Respite Authorization**.**

AlohaCare Fax	**HMSA** Fax	**Kaiser** Fax	**Ohana** Fax	**United** Fax	**CCS** Fax
808-973-0676	808-948-8243	855-416-0995	855-637-2941	800-267-8328	855-637-2941

Department of Human Services
Med-QUEST Division

Medical Respite Person Centered Service Plan

This plan is your opportunity to learn about the Community Integration Services (CIS+) program, share what is important to you, and explore how the program can best support your goals. You are welcome to involve anyone from your support network in creating this plan. If at any point you want to make changes, your plan can be updated at your request.

A. Contact Information

1. Name (as shown on Medicaid or QI Health Plan Card):	
2. Medicaid or Health Plan ID # (If known):	3. DOB (MM/DD/YYYY):
4. If applicable, name of Guardian or Legal Authorized Representative:	
5. Contact Phone Number (indicate cell or house):	6. Contact Email:

7. What are your medical respite goals and needs? (select all that apply)
   - ☐ Recover in a safe, supportive environment.
   - ☐ Improve how I manage my ongoing health conditions.
   - ☐ Get support to take my medications as prescribed.
   - ☐ Work toward stable, long-term housing.
   - ☐ Keep my follow-up appointments and get connected to regular medical or behavioral health care.
   - ☐ Be part of a community with people who may have similar experiences.
   - ☐ Other: _____

8. *[Optional]* What are some barriers to reaching your medical respite goals? (select all that apply)
   - ☐ My health conditions are complicated, and it's hard for me to keep track of everything.
   - ☐ I sometimes have trouble understanding medical information or instructions.
   - ☐ I want support, but I don't always feel ready to make big changes.
   - ☐ Other: _____
   - ☐ None

9. What medical respite benefit are you receiving or are going to receive?
   - ☐ Short-term pre-procedure housing
   - ☐ Short-term post-hospitalization housing
   - ☐ Short-term recuperative care

10. Are you interested in receiving Housing Navigation Supports while in medical respite? This service offers support to help you work toward permanent housing.

☐ Yes, I am interested in Housing Navigation Supports
☐ Maybe, I would like to learn more at another time
☐ No

Sign below if you agree to this person-centered service plan.

Member Signature: _____ Date: _____

If not signing for self, guardian, or legal authorized representative name:

_____

For Health Plan or Delegate Use Only
Was the plan authorized verbally? ☐ Yes ☐ No Health Plan or Delegate Organization Name:_____ Staff Name (print): _____ Staff Signature: _____ Date: _____