

## **APPENDIX I – SUPPLEMENTAL GUIDANCE: REENTRY TARGETED CASE MANAGEMENT MODEL**

### **Table of Contents**

|                                                                                       |    |
|---------------------------------------------------------------------------------------|----|
| Table of Contents.....                                                                | 1  |
| I. Purpose of this Document.....                                                      | 2  |
| II. Introduction.....                                                                 | 2  |
| III. Overview of rTCM Roles and Responsibilities.....                                 | 3  |
| A. Team-Based Approach .....                                                          | 3  |
| IV. rTCM Provider Qualifications and Organizational Requirements.....                 | 7  |
| A. Individual Provider Qualifications.....                                            | 8  |
| B. Provider Organization Qualifications .....                                         | 9  |
| V. rTCM Service Delivery .....                                                        | 9  |
| A. Duration and Timing of rTCM.....                                                   | 10 |
| B. Reentry Care Plan.....                                                             | 11 |
| C. Pre-Release Screenings and Assessments .....                                       | 15 |
| VI. Release and Transitions of Care .....                                             | 16 |
| A. Warm Handoffs .....                                                                | 16 |
| B. Facility Transfers .....                                                           | 17 |
| C. Release Activities .....                                                           | 18 |
| D. Special Considerations.....                                                        | 18 |
| VII. Summary of rTCM Activities, Responsible Entities, and Suggested Timeframes ..... | 19 |

## **I. PURPOSE OF THIS DOCUMENT**

This Supplemental Guidance: Reentry Targeted Case Management Model (“Supplemental Guidance”) provides detailed operational guidance for Reentry Targeted Case Management (rTCM) within Hawai‘i’s Medicaid Reentry Program. This document should be read in conjunction with the Medicaid Reentry Program Policy and Operational Guidance, which serves as the governing document for program requirements. This Supplemental Guidance is designed to support a shared understanding among all participating entities—including carceral facilities, QI Health Plans, rTCM providers, and other community partners—of how the rTCM functions as the central coordination mechanism supporting member transitions from incarceration to the community.

The rTCM model is designed to reduce preventable emergency department utilization, overdose and relapse events, suicide risk, and gaps in medication continuity during the high-risk post-release period, particularly within the first 30 days following release.

This Supplemental Guidance outlines Hawai‘i Med-QUEST Division’s (MQD) expectations for the development and monitoring of the Reentry Care Plan, screenings and assessments, transitions of care, and data sharing. It also clarifies roles and responsibilities across care teams and establishes consistent expectations for both pre- and post-release service delivery, advancing the Medicaid Reentry Program’s goal of improving health outcomes and supporting successful transitions back to the community.

For all other Medicaid Reentry Program policy and operational requirements, refer to the Medicaid Reentry Program Policy and Operational Guidance.

## **II. INTRODUCTION**

Reentry Targeted Case Management (rTCM) includes up to 90 days of pre-release and at least 30 days of post-release case management support. All Medicaid Reentry Program members are eligible for rTCM. As with all services, Medicaid Reentry Program participation is voluntary and individuals may decline services.

CMS describes rTCM as the “critical lynchpin” of the Medicaid Reentry Program because it helps build bridges to needed services and supports for individuals transitioning from incarceration to the community.<sup>1</sup> The **core goals of rTCM** are to:

- **Assess Needs:** Identify and assess physical health, behavioral health, and health-related social needs;
- **Initiate Services:** Support the coordination of pre- and post-release services to address identified needs and ensure continuity of care;
- **Build Member Trust:** Build trust between the member, the rTCM provider, QI Health Plan, and community providers;

---

<sup>1</sup> Centers for Medicare and Medicaid Services. [SHO# 24-004: Provision of Medicaid and CHIP Services to Incarcerated Youth](#). July 23, 2024.

- **Coordinate Across Care Team:** Enable warm handoffs to post-release physical and behavioral health services, social services and supports, and care coordination provided by QI Health Plans, when applicable; and
- **Enhance Access to Community Care:** Promote timely access to appropriate care and services delivered in the community following release.

This Supplemental Guidance describes Hawai'i's Medicaid Reentry Program expectations for rTCM. The rTCM model is designed to support member transitions into the community, be minimally burdensome to carceral facility staff, and align with federal expectations.

### **III. OVERVIEW OF rTCM ROLES AND RESPONSIBILITIES**

#### **A. Team-Based Approach**

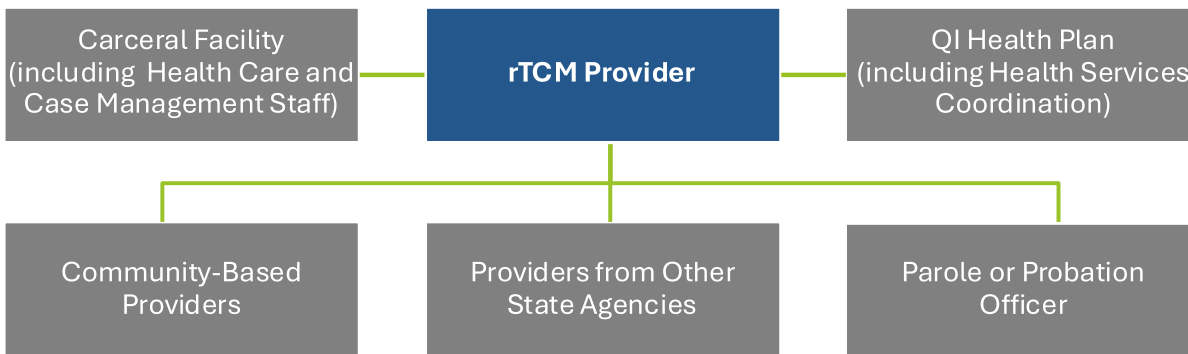
Hawai'i's rTCM model uses a coordinated, team-based approach to support identification of member needs and to develop and implement a Reentry Care Plan. While multiple entities or providers may conduct screenings, assessments, and related services, the rTCM provider is the member's designated Medicaid Reentry Program case manager and serves as the central point of contact for Medicaid Reentry Program case management.

While care coordination activities may be shared across multiple entities (e.g., QI Health Plan care coordination staff, parole and probation officers, carceral facility case managers), the rTCM provider is **accountable for the completion and oversight of all required Reentry Program care coordination activities**, ultimately creating alignment across care team members and preventing duplication. This includes coordinating screening, assessment, care planning, and service linkage across the entities involved in supporting members during reentry. When service referrals are made, the rTCM provider must ensure that referred services are not only scheduled, but successfully accessed by the member, and that any barriers to access are identified and addressed in a timely manner.

The rTCM provider is expected to make reasonable and good faith efforts to complete these activities to the fullest extent possible in the pre-release setting based on the member's length of stay and operational constraints, including in cases of short or unpredictable release timelines. In such cases, the rTCM provider must support post-release connections to services to ensure that required activities are completed in accordance with Medicaid Reentry Program requirements.

This model is intended to reduce fragmentation and promote a more seamless transition to community-based care. **Figure 1** depicts how the rTCM provider serves in this central coordinating role.

**Figure 1: Reentry Targeted Case Management Team-Based Approach**



## 1. rTCM Provider

The rTCM provider is the member's designated Medicaid Reentry Program case manager. The rTCM provider is responsible for coordinating the full scope of required rTCM activities, which may require coordination with carceral facility staff, including medical unit staff and facility-based case managers. The following summarizes rTCM provider activities. Additional details on screenings and assessments, the Reentry Care Plan, and other responsibilities are provided throughout this document.

- Conducting **Reentry Program outreach and engagement**, including informing the member about what services and benefits are covered and what the member can expect from program participation.
- Completing an initial **Reentry health screening** with the member to identify the member's immediate needs, goals, and priorities related to release planning.
- Coordinating **additional screenings and assessments** for the member during the pre-release period, as indicated.
- Developing, monitoring, updating, and finalizing the member's **Reentry Care Plan**.
- **Coordinating services** both pre-release and post-release, including **supporting referrals and connections** to post-release community-based programs and services to address identified needs.
- Participating in **warm handoffs and transitions of care**, including any time there is a change of rTCM provider, new health plan care coordination supports, and other care transitions.

## 2. Carceral Facility

The carceral facility is responsible for facilitating a member's connection to an rTCM provider. This can be accomplished by using any combination of carceral-based or community-based providers. Carceral facility responsibilities include:

- Providing or arranging for **adequate staffing capacity to deliver rTCM** services during the pre-release period. Carceral facilities and QI Health Plans are encouraged to identify possible plan-supported solutions or available community providers and resources that may help meet rTCM capacity needs.

- **Assigning an rTCM provider** to eligible members within their facility.
- Enabling the appropriate **physical space and technology needs** for rTCM appointments.
- Establishing **processes to schedule in-facility appointments** between the member and Medicaid Reentry Program providers, including the rTCM provider.
- Supporting **team-based coordination** by ensuring carceral facility-based medical staff, discharge planners, and other relevant personnel coordinate and share information with the pre-release rTCM provider; supporting coordination with probation and parole officers, as applicable.
- Supporting **warm handoffs** with the member and their care team while the member is incarcerated, including sharing necessary member data and PHI (with member consent), scheduling support with the member, and participation of relevant carceral facility staff, as appropriate.
- Communicating **changes in expected release dates** to the Medicaid Reentry Program care team, including the rTCM provider.
- **Sharing relevant member information** with the rTCM provider to support the Reentry Care Plan and continuity of care, with member consent.

### 3. QI Health Plan

QI Health Plans are responsible for Medicaid Reentry Program administration and will provide the full spectrum of Medicaid coverage to members following release. As part of the member's Medicaid coverage, QI Health Plans may support care coordination needs of a member through the Health Coordination Services (HCS) program, when indicated.<sup>2</sup> As such, QI Health Plan activities to support rTCM may include:

- **Collaborating with carceral facilities to support rTCM capacity needs**, when applicable, through plan-supported solutions (e.g., using plan care coordination staff) or connections to community providers and resources.
- Establishing dedicated **Medicaid Reentry Program resources** to support rTCM provider coordination, including a designated point of contact for the Reentry Program (reentry program liaison(s)); MQD recommends that each QI Health Plan work with carceral facilities to understand what supports may be useful to enable rTCM coordination, such as quick reference materials to facilitate access to plan tools and resources.
- **Sharing relevant member information** with the rTCM provider to support the Reentry Care Plan and continuity of care, with member consent.
- Coordinating with the rTCM provider to connect individuals to and provide **HCS**, where indicated. rTCM providers and QI Health Plan HCS staff are expected to **align on scopes of work** to avoid duplication.
- Supporting and processing **referrals to relevant Medicaid programs** and services, such as Community Integration Services Plus (CIS+), Nutrition Supports, Community Care Services (CCS), and others, so that the member may be enrolled in the program upon release, if possible.

---

<sup>2</sup> QI Health Plan Manual. [Part II: Operational Guidance, Rev. 26.1](#). Health Coordination Services is a QI Health Plan program to coordinate care for members and provide for seamless and continuous coordination of care for the Member with a focus on improving health outcomes.

- Following up with **CAA-eligible members who decline post-release rTCM**. CAA-eligible members must be offered at least 30 days of post-release rTCM. However, as services are always the choice of the member, members may decline post-release rTCM. QI Health Plans should conduct follow-up for individuals declining post-release rTCM to offer rTCM services during the post-release period, if the member is not receiving equivalent case management services, and as long as the member still qualifies for rTCM, as described in [Section V.A. Duration and Timing of rTCM](#).
- Facilitating **transitions of care coordination** post-release, including when rTCM ends.
  - Note: To comply with Section 5121 of the Consolidated Appropriations Act of 2023 (CAA), the QI Health Plan (or the rTCM provider if still engaged) must conduct at least one annual follow up with CAA-eligible individuals 12 months following release from incarceration.<sup>3</sup>

#### 4. Other State Agencies

Other state agencies play an important role in supporting service delivery, care coordination, and connections to community-based programs for certain Medicaid Reentry Program populations. State agency activities may include:

- Providing case management, care coordination, treatment, educational, vocational, or other **supports through agency-administered programs**, as applicable.
- Coordinating with the rTCM provider on case and care management activities being conducted. rTCM providers and State agencies providing any level of case management are expected to **align on scopes of work** to avoid duplication.
- **Reviewing and processing referrals** to agency-operated programs and services for eligible members.
- **Coordinating with the rTCM provider** on service planning and transition activities for members who are engaged with, or may be eligible for, agency programs.
- **Sharing relevant member information** with the rTCM provider to support the Reentry Care Plan and continuity of care, as appropriate.

#### 5. Community-Based Providers

Community-based providers in both pre- and post-release settings may need to collaborate with rTCM providers as follows:

- **Furnishing pre-release services as in-reach providers**, including practitioner office visits, screenings, assessments, diagnostics, and others identified in the Reentry Care Plan (use of in-reach providers dependent on each carceral facility's service delivery approach).
- Coordinating with the rTCM provider and QI Health Plan to **support continuity of care following release**, including follow-up on treatment plans, referrals, and scheduled services.

---

<sup>3</sup> As defined in the statute, eligible individuals ("CAA-eligible individuals") include youth under the age of 21 who are otherwise eligible for Medicaid, youth under 19 who are eligible for CHIP, and youth and young adults formerly in foster care under 26 who qualify as Former Foster Care Children (FFCC) under Medicaid.

- Communicating **updates on member status, treatment progress, and emerging needs** to the rTCM provider, as appropriate and in accordance with applicable consent and privacy requirements.

## 6. Parole and Probation

While parole and probation officers are not rTCM providers and may not serve in this role, rTCM providers are expected to coordinate with these entities. Parole and probation activities may include:

- **Coordinating with the rTCM provider** on case and care management activities being conducted. rTCM providers and parole and probation officers providing any level of case management are expected to **align on scopes of work** to avoid duplication.
- **Sharing other relevant member information** with the rTCM provider to support the Reentry Care Plan and continuity of care.

## IV. rTCM PROVIDER QUALIFICATIONS AND ORGANIZATIONAL REQUIREMENTS

rTCM may be furnished and billed by carceral facility-based or in-reach community providers with appropriate qualifications. rTCM may be provided by the same provider in both pre- and post-release periods or by different providers across those periods; however, continuity with the same rTCM provider across pre- and post-release should be prioritized wherever possible to promote relationship-building, continuity of care, and more effective care transitions.

rTCM providers must abide by all provider requirements outlined in Section V. Provider Requirements of the Medicaid Reentry Guidance, including meeting all applicable provider enrollment, credentialing, and contracting requirements. In addition to meeting all applicable MQD, QI Health Plan, state, and federal requirements, rTCM providers providing services in carceral settings must also comply with applicable carceral facility provider policies and requirements for delivering services to incarcerated individuals. Additional qualifications for rTCM providers exist at both the individual provider and organizational levels, as described below.

### Use of QI Health Plan Staff to Perform rTCM Functions:

QI Health Plan staff are not considered billable rTCM providers under the Medicaid Reentry Program and may not receive reimbursement for furnishing rTCM. However, MQD recognizes that, in certain circumstances and based on mutual agreement between the carceral facility and QI Health Plan, it may be appropriate for QI Health Plans to functionally serve in the rTCM role. For example, a QI Health Plan may elect to use its care coordination staff to provide rTCM activities when provider capacity is limited or when it would best promote continuity of case management.

In these instances, the QI Health Plan may deliver rTCM in alignment with program requirements to the fullest extent possible. However, these activities must be supported through health plan administrative functions and cannot be separately billed or reimbursed through the Medicaid Reentry Program. rTCM provided by Health Plan staff should be reported to MQD as “Health Plan Staff Services” encounters.

MQD encourages carceral facilities and QI Health Plans to work collaboratively on rTCM service planning, provider capacity, and ongoing service delivery to enable timely, person-centered, and appropriate case management support.

## A. Individual Provider Qualifications

rTCM provider qualifications are described below, in alignment with Hawai'i's State Plan.

**Supervising rTCM Providers:** At a minimum, the rTCM provider team must include at least one provider who can: (1) provide rTCM independently without any additional supervision, and (2) supervise the provision of rTCM by eligible supporting rTCM providers. Eligible independent or supervising rTCM providers must be licensed clinicians who furnish rTCM in accordance with their current scope of practice under state law. Supervising rTCM providers must be enrolled with Med-QUEST in HOKU and may bill for rTCM services as the rendering/servicing provider. These include:

- Licensed Clinical Social Worker (LCSW)
- Licensed Mental Health Counselor
- Licensed Marriage and Family Therapist (MFT)
- Licensed Psychologist
- Other licensed practitioners working within health care facilities (e.g., Medical Doctor [MD], Doctor of Osteopathic Medicine [DO], Advanced Practice Registered Nurse [APRN])

**Supporting rTCM Providers:** MQD will also allow additional providers with appropriate licensure or certifications to provide rTCM under the supervision of one of the supervising rTCM providers listed above in accordance with their current scope of practice under state law. Supporting rTCM providers may bill for rTCM services with the Supervising Provider listed as the Rendering/Servicing Provider but may not independently bill without supervision. Eligible supporting rTCM providers may include:

- Licensed Social Worker (LSW)
- Licensed Bachelor Social Worker (LBSW) in an agency setting under supervision
- Associate Mental Health Counselor or Licensed Associate Mental Health Counselor under the supervision of a Licensed Mental Health Counselor
- Associate MFT or Licensed Associate MFT under clinical supervision
- Agency-Affiliated Counselor exempt from licensure<sup>4</sup>
- Agency-Affiliated Social Worker exempt from licensure<sup>5</sup>
- Licensed Registered Nurse working within a healthcare facility or practice
- Associate Psychologist working under the supervision of a licensed psychologist
- Other providers with appropriate licensure or certification in accordance with their current scope of practice under state law, including but not limited to:
  - Relevant certification from a Hawai'i State Agency, such as the Hawai'i Alcohol and Drug Abuse Division, including but not limited to:
    - Certified Substance Abuse Counselor;
    - Certified Prevention Specialist;
    - Certified Clinical Supervisor; or

---

<sup>4</sup> Hawai'i Revised Statutes. [Vol. 10, Chapter 0436-0474, § 435D, Exemptions.](#)

<sup>5</sup> Hawai'i Revised Statutes. [Vol. 10, Chapter 0436-0474, § 467E-6, Exemptions.](#)

- Certified Criminal Justice Professional.

**Exclusion:** Any individual with supervisory control over the member, such as Parole and Probation officers, cannot be an rTCM provider.

**Note:** Unlicensed or non-certified individuals with relevant experience may support rTCM service delivery under supervision but may not bill for or be reimbursed for services.

## **B. Provider Organization Qualifications**

In addition to individual provider requirements, any rTCM provider agencies or organizations furnishing rTCM must meet additional organizational qualifications. The entity must have:

- Experience working with individuals involved with the justice system, individuals with behavioral health needs, individuals at risk of or experiencing homelessness, or other populations with significant and complex health and health-related social needs;
- Knowledge of harm reduction principles and trauma-informed care;
- Knowledge of Med-QUEST services and processes, community resources, and other government assistance programs as well as experience in supporting referrals to such programs;
- Experience conducting screenings and assessments for individuals with complex health and health-related social needs;
- The ability to meet conflict of interest standards, including ensuring that the rTCM provider does not have supervisory control or authority over the member;
- An appropriate staffing model and supervision structure for the team-based model of care;
- Established training protocols to ensure care team knowledge of the Medicaid Reentry Program, rTCM model and service delivery requirements, and available community services and supports; and
- Organizational policies and processes to ensure appropriate risk management and financial solvency.

## **V. rTCM SERVICE DELIVERY**

This section outlines expectations for the delivery of rTCM services across the pre- and post-release periods. rTCM service delivery includes coordination of screenings and assessments, development and execution of the Reentry Care Plan, and facilitation of access to services and supports that address identified member needs.

### **Short Stay Considerations:**

MQD recognizes that the full scope of Medicaid Reentry Program service delivery may not always be feasible prior to release, particularly for individuals with short or uncertain lengths of stay. In these instances, where Medicaid Reentry Program services are not delivered or service delivery is limited during the pre-release period, the carceral facility should make reasonable efforts to **enroll the individual in Medicaid, identify their most urgent health and health-related needs, and establish critical connections to care** and case management to support the member's health and safety following release. Where feasible, the carceral facility should assign an rTCM provider to complete an initial meeting with the member or connect with the member's QI Health Plan's

Health Coordination team to initiate case management supports pre-release. Additionally, **rTCM providers** (where applicable) and the member's **QI Health Plan are expected to engage members following release** to provide needed case management, screenings and assessments, and access to community care.

Please see Section IV.C of the Hawai'i Medicaid Reentry Program Policy and Operational Guidance for more information on service delivery mitigation approaches.

Additionally, as noted throughout this document, QI Health Plans are responsible for supporting compliance with the CAA in the post-release period for members who did not receive the full scope of required services in the pre-release period.

## **A. Duration and Timing of rTCM**

**Pre-Release:** Carceral facilities are responsible for facilitating access to pre-release rTCM services and maintaining sufficient provider capacity through carceral facility-based or in-reach community-based providers. Carceral facilities and QI Health Plans are encouraged to collaborate on possible approaches to meeting rTCM service capacity needs. Provision of rTCM may begin as soon as a member's limited-scope Medicaid Reentry Program coverage is activated, which may occur **up to 90 days prior to release**, and once the carceral facility has assigned an rTCM provider to the member.

**Post-Release:** QI Health Plans are responsible for facilitating access to and maintaining provider capacity for post-release rTCM services. Capacity can be met through community-based providers or QI Health Plan care coordination staff performing rTCM functions, prioritizing provider continuity between pre- and post-release settings where possible. Provision of post-release rTCM begins upon release from incarceration and continues for **at least 30 days following release and for up to 12 months total**. Post-release rTCM beyond 30 days may be authorized<sup>6</sup> by the QI Health Plan if appropriate for the member based on the following criteria:

- The member is not receiving equivalent case management services from another agency, provider, or the QI Health Plan;
- The member continues to have health and health-related goals in their Reentry Care Plan that an rTCM provider could help address *OR* the member did not receive pre-release rTCM and is newly engaging in the program; and
- The member wants to continue receiving post-release rTCM.

Members may no longer receive, and QI Health Plans may not reauthorize, post-release rTCM when:

- rTCM is no longer necessary to attain health and health-related goals identified in the Reentry Care Plan;
- The member transitions to other equivalent case management supports from another agency, provider, or the QI Health Plan;
- The member becomes ineligible for Medicaid; or
- The member declines ongoing post-release rTCM, or the member is unable to be reached.

---

<sup>6</sup> MQD recommends authorizing additional rTCM in three (3) month increments.

**NOTE:** MQD will provide additional guidance on prior authorization processes for post-release rTCM extending beyond 30 days in a future version of Guidance.

## B. Reentry Care Plan

This section describes the elements of the Reentry Care Plan and associated pre- and post-release activities to develop, monitor, and execute against it.

### 1. Elements of the Reentry Care Plan

The Reentry Care Plan is a person-centered care plan that must:

- Identify and **summarize the member’s needs, screening and assessment results, and goals** related to health needs, social needs, and community transitions.
- Establish a **care plan for pre-release services**, including screenings and assessments across the domains of care and other services such as MAT and peer supports, as available. This includes supporting the member in obtaining any medications and DME upon release or facilitating timely community-based access if not provided at release.
- Establish a **care plan for post-release services**, including documentation of referrals, scheduled appointments, provider hand-offs, prior authorizations, and other activities completed to connect the member to planned services and supports that address identified needs across domains of care. This should also include:
  - A plan for **engagement of a member’s other care management or social supports** (e.g., QI Health Plan HCS staff, probation, parole, family, friends, or other social support circles) who may support Reentry Care Plan execution or need to coordinate with the rTCM provider.
  - Completion of referrals to relevant programs and entities, as indicated, including but not limited to:
    - Notification to the member’s QI Health Plan of possible **need for CIS+<sup>7</sup> or Nutrition Supports services** to address the member’s housing and food needs.
    - Notification to the member’s QI Health Plan if the member has possible long-term services and supports (LTSS) needs, Special Health Care Needs, Expanded Health Care Needs, or other **Health Coordination Services qualifying needs** so that the QI Health Plan can enroll the member in Health Coordination Services, complete a Health and Functional Assessment (HFA), and develop a Health Action Plan (HAP).<sup>8</sup>
    - Notification to the member’s QI Health Plan of possible **need for the CCS program** due to a diagnosis of Severe Mental Illness/Serious and Persistent Mental Illness (SMI/SPMI).

---

<sup>7</sup> See [MQD Memo QI-2314D, CCS-2303D, Community Integration Services \(CIS+\) Implementation Updated Guidelines](#), Appendix B, for the CIS+ Referral Form.

<sup>8</sup> QI Health Plan Manual. [Part II: Operational Guidance, Rev. 26.1](#). See Chapter 2: Eligible Health Coordination Services Populations and Chapter 5: Special Health Care Needs and Expanded Health Care Needs.

- Referral to the Department of Health’s **Adult Mental Health Division (AMHD)** to connect the member to mental health and case management services, including residential treatment, as applicable.
- Referral to the Department of Health’s **Child and Adolescent Mental Health Division (CAMHD) Support for Emotional and Behavior Development (SEBD) Program** for individuals ages three through 20 to connect the member to services.
- Referrals to other programs and services to address identified member housing, nutrition, transportation, interpersonal violence experience, or other health-related social needs (HRSN).
- **Document completed Medicaid Reentry Program services**, including screenings and assessments across the domains of care.
- Include a **list of individuals or organizations** involved in the member’s care that identifies those who should receive the finalized Reentry Care Plan, as appropriate and with the member’s consent. This list may include the member, post-release rTCM provider, QI Health Plan Health Services Coordinator, case managers from other state agencies, social support circle members, and identified community-based providers.
- Document the member’s **Medicaid enrollment information**, including, for example, the member’s Medicaid ID number, health plan ID number, and other information to support the member’s access to services in the community post-release.

## 2. Pre-Release Reentry Care Plan Development, Monitoring, and Finalization

The rTCM provider is responsible for development, monitoring, and finalization of the Reentry Care Plan during the pre-release period. During this period, the primary goal of rTCM is to identify the member’s clinical and non-clinical needs, assess risks and priorities, and develop a comprehensive, person-centered Reentry Care Plan for needed pre-release services and transitioning to the community. Key activities and associated timeframe recommendations to accomplish this are outlined below.

**Note:** Timeframe expectations for rTCM activities may not apply, or may differ from those outlined below, when a provider or organization is already engaged in an individual’s care prior to the 90-day pre-release period.

- **Initial Member Engagement and Reentry Health Screening:** The initial rTCM appointment should be scheduled ***within one (1) week*** of when the member’s Medicaid Reentry Program coverage is activated, if feasible. During this appointment, the rTCM provider will engage the member, build rapport, and educate the member on what to expect from participating in rTCM and the Reentry Program. The provider will also complete an initial Reentry health screening to identify any needs for additional screenings, assessments, or referrals.
- **Development of the Reentry Care Plan:** The rTCM provider should develop the Reentry Care Plan that contains all required elements ***within three (3) weeks*** of the initial rTCM appointment, if feasible.
- **Implementation of Pre-Release Services in the Reentry Care Plan:** The rTCM provider must support the implementation of pre-release Reentry Care Plan activities, with the goal

that all services and supports identified to be provided pre-release are initiated and accessed during incarceration. This occurs on an ongoing basis during the pre-release period and includes:

- Coordinating and supporting the completion of the member's Reentry Wellness Exam **within fourteen (14) days** of the initial rTCM appointment, if feasible.
- Other **ongoing** activities, as needed, such as arranging and scheduling appointments; confirming attendance at scheduled appointments and facilitating rescheduling; and coordinating with facility-based and community-based providers, QI Health Plans, and other care teams.
  - **Note:** The rTCM provider should **leverage health plan resources**, such as provider finder tools and directors, to support rTCM activities and ensure the individual is being referred to the most appropriate resource.
  - Supporting **release medications**. In instances where medications cannot be provided at the time of release (e.g., due to unexpected release, medications requiring in-person administration, etc.) or for medications that cannot be dispersed as a full 30-day supply (e.g., methadone), rTCM providers must establish alternative arrangements in the community for uninterrupted access (with a gap of no more than three days following release). Examples of alternative arrangements include:
    - Providing a physical copy of prescriptions for the member to fill at a community pharmacy;
    - Sending prescriptions to a Medicaid-enrolled community pharmacy near the member's planned living destination for post-release pickup;
    - Allowing the member to come to the facility-based pharmacy on the next business day or as soon as feasible;
    - Establishing MAT treatment in the community; or
    - Otherwise ensuring the member has appointments scheduled with community-based providers to maintain continuity of care.
- **Supporting Maintenance of Coverage:** The rTCM provider is responsible for supporting the member in maintaining Medicaid coverage during the pre-release period. This may include assisting the member with the completion of any required renewals, such as helping the member obtain any information or documentation necessary.
- **Monitoring the Reentry Care Plan:** The rTCM provider must meet with the member **at least monthly** to review the Reentry Care Plan, document progress towards achieving care plan goals, and modify based on member needs. Updates may require that the rTCM Provider revisit information obtained during the initial Reentry health screening or take into consideration any new screenings or assessments conducted by other providers.
- **Finalizing the Reentry Care Plan:** At or near **the time of the member's release**, the rTCM provider must finalize the Reentry Care Plan and share it with the member, individuals and entities in their care team, and others within their social support circles, as appropriate.

### 3. Post-Release Reentry Care Plan Continuity and Monitoring

Post-release rTCM providers are responsible for executing, monitoring, and adapting the Reentry Care Plan during the post-release period. During this phase, the primary goal of rTCM is to support successful community integration by ensuring that planned services are initiated, barriers to care

are identified and addressed, and the care plan reflects the member's evolving needs. Key activities include:

- **Immediate Post-Release Follow-Up:** The rTCM provider must follow up with the member immediately following release to assess urgent needs and confirm that the member is able to access planned services and supports, including supporting the member in obtaining any medications and DME if they were unable to receive them at release. MQD recommends two post-release follow-ups: the first ***within one to two (1-2) days of release*** (ideally within 24 hours of release) and the second ***within seven (7) days of release***.
- **Implementation of the Reentry Care Plan:** The rTCM provider must support the implementation of the Reentry Care Plan, with the goal that all services and supports identified prior to release are initiated and accessed in the community. This occurs on an ***ongoing basis*** during the post-release period and includes: confirming attendance at scheduled appointments and facilitating rescheduling as needed; addressing barriers to service access, such as transportation or language barriers; coordinating with community-based providers, QI Health Plans, and other care teams; and other activities necessary to implement the member's Reentry Care Plan.
- **Monitoring the Reentry Care Plan:** The rTCM provider must continue to monitor and revise the Reentry Care Plan to ensure it reflects the member's needs and changes in health status, social supports, or service needs. This occurs on an ***ongoing basis*** during the post-release period and includes: meeting with the member; documenting progress against the Reentry Care Plan goals; coordinating needed screenings or reassessments; completing referrals for new services or programs; supporting prior authorization processes; ensuring continuity of medications and DME, such as access to community-based refills; and other activities to meet evolving member needs.
  - *Note:* Pursuant to federal guidance, and in addition to regular monitoring and follow-up, the rTCM provider (if still engaged) or the member's QI Health Plan must conduct **at least one annual follow-up with CAA-eligible** individuals following release from incarceration (12 months following release from incarceration).<sup>9</sup> In most instances, the annual follow-up will likely be conducted by the QI Health Plan.
- **Supporting Maintenance of Coverage:** The rTCM provider is responsible for supporting the member in maintaining Medicaid coverage during the post-release period. This may include assisting the member with the completion of any required renewals, such as helping the member obtain any information or documentation necessary. The rTCM provider may also support the member with activities related to compliance with applicable Medicaid Community Engagement Requirements under Public Law No: 119-21 (see also Medicaid Reentry Program Policy and Operational Guidance, Section III.C.1. Medicaid Application Support). Such support may include assistance with achieving and documenting Reentry Care Plan goals related to education, employment, and/or vocational training needs. For dually eligible individuals, the rTCM provider must also support enrollment or reenrollment in Medicare, as appropriate (see also Section VI.D.1. Releasing Dually Eligible Individuals).

---

<sup>9</sup> Centers for Medicare and Medicaid Services. [SHO# 24-004, RE: Provision of Medicaid and CHIP Services to Incarcerated Youth](#). July 23, 2024.

## C. Pre-Release Screenings and Assessments

The provision of rTCM and development of a Reentry Care Plan require comprehensive assessments of member needs across multiple domains of care. Certain screenings and assessments may be completed by the rTCM provider, while others must be completed by qualified clinicians. The rTCM provider is responsible for coordinating necessary screenings and assessments (and reassessments, as needed) to identify and address the member's needs.

### 1. Initial Reentry Health Screening

rTCM begins with an initial appointment between the member and the rTCM provider, during which an initial Reentry health screening will be completed to support the identification of strengths and needs across multiple domains of care, and to identify the need for additional screenings, assessments, or referrals. See [Section V.B. Reentry Care Plan](#) of this document for more information.

#### Short Stay Considerations:

For members with short stays or unanticipated releases, the initial Reentry health screening may be used to identify the most urgent needs and support prioritization of time-sensitive services (e.g., MAT).

### 2. Comprehensive Screenings and Assessments

Following the initial rTCM appointment, the rTCM provider will continue to assess for health and health-related social needs, identifying other screenings and assessments, as indicated for each member, across the following domains of care. These domains are summarized below, with a more detailed matrix outlining MQD's expectations for screening and assessment delivery by domain in [Appendix D – Detailed Service Descriptions](#).

- **Physical Health:** including identification of prior or potentially undiagnosed chronic conditions, medication needs, DME needs, current preventive care needs (e.g., vaccinations), and need for further clinical consultations, assessments, or treatments.
- **Behavioral Health:** including review of mental health history and identification of current symptoms, potentially undiagnosed conditions, medication needs, and need for further clinical consultations, assessments, or treatments.
- **SUD Needs:** including review of prior SUD diagnoses and treatment history and identification of current MAT needs, medication needs, post-release treatment needs, and need for further clinical consultations, assessments, or treatments. Includes all types of SUDs, including Alcohol Use Disorders (AUDs), Stimulant Use Disorders (StimUDs), and Opioid Use Disorders (OUDs).
- **Dental Health:** including an oral and dental health screening for all members, with specific screening requirements for members under age 21 to align with EPSDT standards.
- **Functional Needs:** including assessment of medication management needs, ability to perform activities of daily living (ADL) or instrumental activities of daily living (IADL), and potential post-release LTSS needs; if appropriate, complete referrals to the member's QI Health Plan for further screenings, assessments, and connections to services.

- **Health-Related Social Needs (HRSN):** including identification of HRSN across various domains identified below and supporting referrals to applicable programs that can address identified HRSN. HRSN screening may use the Accountable Health Communities (AHC)-HRSN Screening Tool or other validated HRSN screening instruments.
  - **Housing Needs:** including identification of anticipated housing upon release and need for housing navigation or support services.
  - **Nutrition Needs:** including identification of any anticipated post-release nutrition insecurity or need for nutrition support services upon release.
  - **Interpersonal Safety Needs:** including any identification of anticipated post-release experiences or concerns regarding interpersonal safety, exposure to intimate partner violence, fear of physical or emotional harm, and other related needs.
  - **Educational and Vocational Needs:** including understanding of current educational status and identification of any educational, training, or employment support needs to support reentry.
  - **Other Health-Related Social Needs:** including identification of needs related to transportation, cellphone or internet access, utilities, and other social needs.
- **Personal Network Needs:** including identification of possible social support needs and how individuals or organizations (e.g., family, friends, parole, probation, Narcotics Anonymous [NA] and/or Alcoholics Anonymous [AA], as needed, and others in the individual's support circle) may be involved in the post-release care plan.

### 3. Integration of Existing Member Information

To the extent possible and with appropriate member consent, the Reentry Care Plan should build on and incorporate member information already available from screenings and assessments completed by the carceral facility during incarceration to support continuity of care and reduce duplication.<sup>10</sup> If used, relevant findings from previous screenings and assessments should be documented in the member's Medicaid Reentry Care Plan to inform pre- and post-release service planning.

## VI. RELEASE AND TRANSITIONS OF CARE

This section outlines requirements and expectations for warm handoffs during release, provider changes, facility transfers, and other situations that may affect service delivery and continuity of care.

### A. Warm Handoffs

Warm handoffs are a required component of rTCM and include both live meeting and data sharing components. A warm handoff must include: (1) a synchronous meeting (in-person or telehealth) involving the member and relevant care team members; and (2) timely sharing of member information, including the Reentry Care Plan and other supporting records. If a member declines to

---

<sup>10</sup> Carceral facilities may not bill Medicaid for screenings and assessments conducted prior to activation of or out of scope for a member's limited-scope Medicaid Reentry Program coverage.

participate in a warm handoff or where member participation is not possible, care team members may choose to conduct the handoff asynchronously, as appropriate.

**Goals:** A warm handoff serves four key purposes:

- **Review and refine the Reentry Care Plan** with the member, the rTCM provider(s), and the member's QI Health Plan.
- **Establish a trusted working relationship** between the member and the new rTCM provider and/or QI Health Plan care coordination staff (includes a QI Health Plan Health Services Coordinator or other QI Health Plan case manager).
- **Formally transfer case-management responsibility** from the rTCM provider to the new rTCM provider or QI Health Plan care coordination staff.
- **Share the Reentry Care Plan and any relevant medical or care planning records** with the new rTCM provider or QI Health Plan care coordination staff, with member consent.

**Scenarios:** The rTCM provider must conduct a warm handoff at key transition points, including:

- **Changes in rTCM provider**, such as staffing changes, facility transfers, or transitions from pre- to post-release rTCM;
- **Initiation of additional case management services**, such as engagement with HCS, parole or probation, or other entities with case management functions;
- **Near the time of release**, ideally within fourteen (14) days prior to release but no later than fourteen (14) days following release; and
- At or near the **conclusion of rTCM services**, when transitioning case management responsibility to a QI Health Plan or other provider.

## B. Facility Transfers

Transfers between carceral facilities may affect the availability and continuity of Medicaid Reentry Program services. Implementation partners must prioritize continuity of care through timely information sharing and coordination.

- If a member is transferred to a **facility that is not yet providing pre-release services**:
  - The member remains eligible, but will not receive services at the receiving facility;
  - The transferring facility and rTCM provider must share the Reentry Care Plan, assessment results, and other relevant documentation with the member's QI Health Plan prior to transfer or as soon as practicable following transfer; and
  - The QI Health Plan is responsible for ensuring that federally-required (e.g., screenings for CAA-eligible individuals) and medically necessary services (e.g., medications and DME) are initiated or completed in the post-release period.
- If a member is transferred to a **facility that provides a different scope of pre-release services**:
  - The member remains eligible and should receive any available pre-release services at the receiving facility, as indicated by member need;
  - The transferring facility and rTCM provider must share the Reentry Care Plan and supporting documentation with the receiving facility, the member's QI Health Plan, and the new rTCM provider, if applicable; and

- The receiving facility and rTCM provider must continue implementation of the Reentry Care Plan, where feasible.
- If a member is transferred to a **facility that provides the same scope of pre-release services**:
  - The member's eligibility and scope of available services are not impacted;
  - The transferring facility and rTCM provider must ensure timely transfer of the Reentry Care Plan, assessment results, and other relevant documentation to the receiving facility and rTCM provider, as applicable; and
  - The receiving facility and rTCM provider must continue implementation of the Reentry Care Plan, where feasible.

## C. Release Activities

rTCM providers are required to conduct certain activities at or near the time of release, as described throughout this document. Where unexpected releases limit the ability to conduct these release activities prior to release, the rTCM provider should complete these activities as soon as practicable following release. Release activities include:

- **Finalizing the Reentry Care Plan** and sharing it with the member, individuals and entities in their care team, and others within their social support circles, as appropriate.
- Conducting a **warm handoff** with the member's post-release rTCM provider and/or QI Health Plan Health Coordination team, as applicable.
- Supporting **release medications** or establishing alternative arrangements to ensure uninterrupted access to medications following release.

## D. Special Considerations

### 1. Releasing Dually Eligible Individuals

**rTCM Provider Responsibilities:** While Medicare coverage is not suspended during incarceration and eligible individuals are still able to enroll and/or re-enroll in Medicare while in custody, Medicare will generally not pay for medical items and services while an individual is incarcerated. Individuals who are enrolled in Medicare Part C and Medicare Part D (Medicare Advantage) during incarceration, including D-SNPs, will be disenrolled from Medicare Parts C and D and moved to Traditional Medicare (Medicare Part A and B).

For members dually eligible for Medicaid and Medicare, or who become eligible for Medicare during incarceration (e.g., reaching age 65 or acquiring a Medicare-qualifying disability during incarceration), the rTCM provider must support Medicare enrollment during or shortly following incarceration, or reactivation of Medicare coverage following release, if the member requests enrollment or re-enrollment support, and as applicable.<sup>11</sup> The rTCM provider must provide information on enrollment options, including Dual Eligible Special Needs Plans (D-SNPs), based on

---

<sup>11</sup> Following release, eligible individuals will be eligible for a Special Enrollment Period (SEP) to enroll or re-enroll in Medicare Parts A, B, C, and/or D. If the Medicare-eligible individual fails to enroll during the SEP for formerly incarcerated individuals, they will be subject to the Late Enrollment Penalty (LEP). For additional information, see Centers for Medicare and Medicaid Services, ["Incarcerated Medicare Beneficiaries."](#)

member preference. If additional assistance is needed, the rTCM provider should direct the member to:

- The Hawai'i State Health Insurance Assistance Program (SHIP), which provides counseling on coverage options and enrollment support (808-586-7299 or 1-888-875-9229; <https://www.hawaiiiship.org/>)
- 1-800-MEDICARE (1-800-633-4227) or <https://www.medicare.gov/>

**QI Health Plan Responsibilities:** If a QI Health Plan identifies a dually eligible member who may benefit from D-SNP enrollment support, the QI Health Plan should conduct outreach and offer assistance.

## 2. Releasing Individuals with LTSS Needs

For individuals with LTSS needs, the pre-release rTCM provider should contact the QI Health Plan to initiate engagement with HCS to complete an HFA and create the HAP. The rTCM provider and QI Health Plan HCS staff must coordinate to ensure that all necessary LTSS are arranged prior to the individual's release into the community.

## 3. Releasing Individuals into Housing Insecurity

For individuals being released into housing insecurity, the rTCM provider must support identification of housing needs and coordinate referrals to appropriate services and supports. This may include referral to Hawai'i's CIS+ program through the member's QI Health Plan or CCS for Medicaid-covered housing navigation and support services, as well as connection to the Coordinated Entry System, AMHD residential treatment, and other community-based housing providers, as applicable. rTCM providers and their organizations are expected to maintain knowledge of available housing programs and resources to ensure referrals are appropriate and aligned with the member's needs.

## 4. Releasing Individuals to Hawai'i State Hospital

Individuals being transferred to the Hawai'i State Hospital are not eligible for the Reentry Program. For individuals being transferred to Hawai'i State Hospital, pre-release Reentry services will end. If the individual already has an rTCM provider and Reentry Care Plan, the rTCM provider must share information with the individual's QI Health Plan, including a copy of the Reentry Care Plan, so that the QI Health Plan can assume care coordination and case management responsibilities following release.

# VII. SUMMARY OF rTCM ACTIVITIES, RESPONSIBLE ENTITIES, AND SUGGESTED TIMEFRAMES

**Table 1** below identifies the entities responsible for completing the rTCM activities described above and provides MQD's suggested timeframes for their completion. MQD recognizes the realities of delivering care within carceral facilities, and that short-term stays, unexpected releases, and uncertain lengths of stay may impact the feasibility of conducting these rTCM activities within the suggested timeframes. These suggested timeframes are best practices rather than specific operational and service delivery requirements. Carceral facilities must make

reasonable efforts to complete these activities within the suggested timeframes to the extent possible.

**Note:** Timeframe expectations for rTCM activities may not apply, or may differ from those outlined below, when a provider or organization is already engaged in an individual’s care prior to the 90-day pre-release period.

**Table 1. rTCM Activities, Responsible Entities, and Suggested Timeframes**

| <b>rTCM Activity</b> <i>(where needed)</i>                                                              | <b>Responsible Entity</b>                            | <b>Suggested Timeframe</b>                                                             |
|---------------------------------------------------------------------------------------------------------|------------------------------------------------------|----------------------------------------------------------------------------------------|
| Assignment of rTCM Provider                                                                             | Carceral facility                                    | Between 120-90 days pre-release                                                        |
| Initial rTCM appointment and completion of Reentry Health Screener                                      | Carceral facility and rTCM provider                  | Within 1 week of being identified as eligible for the Reentry Program                  |
| Conducting Reentry Program outreach and engagement                                                      | Carceral facility and rTCM provider                  | Between 120-90 days pre-release or during the initial rTCM appointment                 |
| Coordinate and complete Reentry Wellness Exam                                                           | Carceral facility and rTCM provider                  | Within 14 days of initial rTCM provider appointment                                    |
| Coordination and completion of additional screenings and assessments                                    | Carceral facility and rTCM provider                  | As potential needs are identified                                                      |
| Development of Reentry Care Plan                                                                        | rTCM provider                                        | Within 21 days of initial rTCM provider contact                                        |
| Monitoring, follow-up, and updates to Reentry Care Plan                                                 | rTCM provider                                        | At least monthly following initial Reentry Care Plan development                       |
| Complete referrals to relevant programs for post-release services (e.g., HSC, CCS, CIS+, etc.)          | rTCM provider                                        | As soon as feasible during pre-release period, so member can be connected upon release |
| Finalizing and sharing the member’s Reentry Care Plan                                                   | rTCM provider                                        | At or near time of release                                                             |
| Post-release provision of Medicaid Reentry Program services (e.g., medications not provided at release) | Carceral facility, rTCM provider, and QI Health Plan | As soon as feasible within 7 days of release                                           |
| First Post-Release Follow-up                                                                            | rTCM provider and QI Health Plan                     | Within 1-2 days post-release, ideally within 24 hours of release                       |
| Second Post-Release Follow-up                                                                           | rTCM provider and QI Health Plan                     | Within 7 days of release                                                               |
| Ongoing Provision of Post-Release rTCM Services                                                         | rTCM provider and QI Health Plan                     | For at least 30 days and up to 12 months post-release                                  |

| <b>rTCM Activity</b> <i>(where needed)</i>     | <b>Responsible Entity</b>                                       | <b>Suggested Timeframe</b>                                                                                                                                                                   |
|------------------------------------------------|-----------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Warm Handoffs                                  | rTCM provider, QI Health Plan, and applicable care team members | As soon as practicable prior to or shortly following transitions of care<br><i>For warm handoffs at release, within 14 days prior to release but no later than 14 days following release</i> |
| Annual Monitoring for CAA-Eligible Individuals | rTCM provider (if still engaged) and QI Health Plan             | 12 months following release                                                                                                                                                                  |