Housing – 1115 Waiver Services Framework

	Example – California	*DC MCAC HSR – Discussions*	
		Adult Population	**Youth and Family Population**
Service Name:	Medical Respite	Short-term pre-procedure and/or post-hospitalization housing	
Service Description:	*Short-term residential care for individuals who no longer require hospitalizations but still need to heal from an injury or illness and whose condition would be exacerbated by an unstable living environment. Allows individuals to continue their recovery and receive post-discharge treatment while obtaining access to primary care, behavioral health services, case management, and other supportive social services. Includes interim housing with a bed and meals and ongoing monitoring of the individual's ongoing medical or behavioral health conditions.*	Participants described various models of short-term housing for individuals who no longer require hospitalization but still need a stable environment for recovery. This includes existing respite programs in DC like *Volunteers of America's* two-phase program, where Phase 1 focuses on medical stability (30 days) and Phase 2 on housing stability (150 days). *Joseph's House* and *Christ House* offer similar services in DC, focusing on end-of-life care, substance use disorder treatment, and 24/7 nursing care, often with a flexible length of stay based on individual needs. These services aim to ensure individuals can recover in a safe, stable environment and access necessary medical and social services.	*(Nothing was discussed during this session)*
Beneficiary Eligibility Criteria:	*Individuals who are post-hospitalization or at risk of hospitalization and meet HUD definition of homeless or at risk of homelessness, have housing that would jeopardize their health and safety without modifications, or who live alone with no formal supports.*	Participants highlighted that beneficiaries must meet certain medical criteria, often those recently discharged from hospitals or at risk of hospitalization. *Volunteers of America* noted that their services target individuals with behavioral health stability needs, while *Joseph's House* focuses on those requiring acute care, including HIV-positive patients and end-of-life care. *Christ House* serves a broad range of high-acuity individuals, including those undergoing cancer treatment or dealing with substance use disorders, in addition to individuals pre and post procedure (for example for colonoscopy preparation, or post-surgical care).	Participants noted that youth experiencing homelessness, or families experiencing homelessness are more likely to have access to non-congregate shelter resources and transitional programs like rapid rehousing as compared to single adults, and may have less incidence of chronic and acute health needs. However, participants also noted that there are some gaps in respite services for younger individuals. They highlighted that medical criteria might exclude some younger beneficiaries who would benefit from these services.
Frequency:	*As needed*	As needed, based on individual medical needs and service availability.	*(Nothing was discussed during this session)*
Duration:	*No more than 90 days in continuous duration*	The length of stay varies by program and phase. Participants from *Volunteers of America* mentioned a 30-day average stay for Phase 1, with extensions to 150 days in Phase 2. *Joseph's House* offers stays starting at 90 days, with flexibility depending on individual circumstances. Christ House length of stay is 4-6 weeks on average with variation based on needs of patient.	*(Nothing was discussed during this session)*
Setting:	*In-Person*	Participants mentioned in-person residential care, primarily in medical respite facilities with access to ongoing nursing, social work, and other supportive services.	*(Nothing was discussed during this session)*

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Provider Staffing Qualifications:	*Providers must have experience and expertise with providing these unique services. Managed care plans can adopt or adapt local or national standards for recuperative care or interim housing. Direct care worker (bachelor's degree or higher), psychiatric professional (bachelor's degree or higher), supervisor (bachelor's degree or higher).*	Participants emphasized that staffing qualifications vary but generally include experienced professionals, such as registered nurses, social workers, and peer support staff. *Christ House* operates with 24/7 nursing care and partners with *Unity Health* for clinical care. *Hope Has a Home* utilizes staffing from Pathways to Housing DC, Unity, and VOA. Participants noted that while some programs, like *Joseph's House*, are not reimbursed by Medicaid, they still maintain federal funding and other grant sources.	*(Nothing was discussed during this session)*
Staffing Ratio/ Caseload:	*1 direct care worker for 10-20 residents, 1 psychiatric professional for 4 direct care workers, 1 supervisor for 10 direct care workers*	A participant from *Christ House* noted that staffing models are designed to support high-acuity care, including end-of-life services and cancer treatment, while *Joseph's House* provides a smaller-scale, flexible staffing model based on need.	*(Nothing was discussed during this session)*
Other Considerations:	*CMS allows up to a combined 6 months, once per year, with the time period assessed on a rolling basis.*	Participants discussed challenges in connecting individuals to permanent housing post-respite, with *Christ House* and *Volunteers of America* emphasizing the importance of better data-sharing pathways to improve referral processes. Providers emphasized the importance of housing navigation and community integration supports, and are often providing these services as part of a second program stage (for 30 days or more), after acute health needs are stabilized, and in preparation for discharge. Individuals with long term chronic homelessness and health needs may require permanent supportive housing and need long term placement options following respite care.	*(Nothing was discussed during this session)*

Nutrition – 1115 Waiver Services Framework

DC MCAC HSR – Discussions

	Adult Population	Youth and Family Population
Service Name:	Home delivered meals	
Service Description:	Defining various levels of home delivered meals: • Medically-tailored: A participant suggested that for meals to qualify as "medically-tailored" they need to be designed by a registered dietician. Another participant recommended that the meals meet the Food is Medicine Coalition (FIMC) accreditation standards • Medically-supportive: *(No suggestions made during the session)* • Nutritionally complete: A participant suggested that meals should meet the definition of "nutritionally complete" as outlined by the U.S. Department of Health and Human Services (HHS), ensuring that each food intervention provides all essential nutrients required for maintaining health. See this website for addition information.	*(Nothing was discussed during this session)*
Beneficiary Eligibility Criteria:	Various priority populations were identified throughout the discussion, including diabetes, cancer, pregnancy, hospice, children, and seniors. Several participants expressed a desire for a data-driven approach to identify the highest priority populations to target. Participants highlighted that home delivered meals could be part of a continuum of 1115 nutrition services and that DHCF should consider the living status of beneficiaries when determining what type of 1115 nutrition service may be best suited to the situation. For home delivered meals, determining if the beneficiary is homebound might be a requirement. Participants discussed how beneficiaries might be screened for eligibility and several MCOs in attendance shared some information about their current screening policies and procedures. Another participant also mentioned that many care coordinators are conducting similar screenings and some results may be shared with DHCF already.	A participant emphasized the importance of including mothers and babies in the screening process, ensuring that maternal and child health needs are considered as part of the eligibility criteria. A participant highlighted that in their program, up to four family members can receive benefits related to pregnancy, underscoring the broader impact of family health. A participant pointed out the *Food is Medicine* program at Children's National, which could serve as a model. They also mentioned FlipRX and T2 diabetes programs as examples that could be incorporated into the eligibility and screening considerations for the program.
Frequency:	*(Nothing was discussed during this session)*	*(Nothing was discussed during this session)*
Duration:	*(Nothing was discussed during this session)*	*(Nothing was discussed during this session)*
Setting:	*(Nothing was discussed during this session)*	*(Nothing was discussed during this session)*
Provider Staffing Qualifications:	A participant emphasized the necessity of having a registered dietician on staff to ensure that meals are designed and approved with the appropriate nutritional and medical considerations in mind. This requirement would help maintain the quality and integrity of the program. Some participants raised concerns that involving a dietician could become a barrier for individuals who lack access to preventive care so participants recommended continuing to think about how the service could be designed to prevent this from becoming an obstacle.	*(Nothing was discussed during this session)*
Staffing Ratio/ Caseload:	*(Nothing was discussed during this session)*	*(Nothing was discussed during this session)*

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Other Considerations:	A participant suggested that any implemented program should include training to ensure the program leverages and enhances existing initiatives. Several participants emphasized the need for strong connections to other existing initiatives, like the Diabetes Prevention Program (DPP), to maximize impact. Several participants also noted that beneficiary engagement and communication will also be important to ensure success.

Reentry – 1115 Waiver Services Framework

	CMS Requirements	*DC MCAC HSR – Discussions*	
		Adult Population	**Youth and Family Population**
Service Name:	Targeted Case Management	Targeted Case Management	
Service Description:	• *Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social, or other services;* • *Development (and periodic revision) of a specific person-centered care plan based on the information collected through the assessment;* • *Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services, including activities that help link the individual with medical, social, and educational providers or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and* • *Monitoring and follow-up activities, including activities and contacts that are necessary to ensure that the care plan is effectively implemented and adequately addresses the needs of the eligible individual and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and*	DOC discussed how different entities within the Department of Corrections (DOC) provide case management. They noted that targeted case management takes place, but two separate entities and systems are involved. Community organizations and DOC manage different parts of the case management process. **Coordinating behavioral health services:** Participants acknowledged that DBH services would need a substantial re-think before CSAs engage in in-reach for consumers receiving "Community Support" level care. Participants advised that current structures and reimbursement mechanisms do not incentivize this type of engagement. They suggested that a conversation with Assertive Community Treatment (ACT) providers might be more productive, although even that would depend on the likelihood of release, which is not always predictable within the 90-day window. • Working with DOC to identify different populations to know when the release date is has assisted some organizations. DBH Core Service Agencies are reluctant to see their consumers in the DOC because they believe they won't be reimbursed. It would be great if DC could apply time credits sooner to have a better idea of when individuals are to be released. If the release date is unknown, then how can services be provided and how are other jurisdictions handling this? • Participants noted that some services have existed in other forms without billing Medicaid. Providers can continue offering services post-release, but these may not be Medicaid billable. Community Service Agencies (CSAs) have, in some cases, been reimbursed for engaging with incarcerated clients. Although few took advantage of this, those who did made a significant impact on their clients.	**TCM warm handoffs and timely release:** The group discussed the importance of warm handoffs during the transition of care. The CAA requires that any client transfer from one caregiver to another must occur through a handoff meeting, ensuring a smooth transition rather than a cold referral. Participants raised concerns about how new providers, who are mandated to follow this process, will implement it effectively.

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	including at least one annual monitoring. • *See this link for further clarification on definitions*		
Beneficiary Eligibility Criteria:	*All waiver beneficiaries must be provided TCM services, though the frequency and duration of services can vary based on identified need*	Participants discussed the need to establish clear eligibility criteria for services to design an effective framework of care. This framework would help ensure that services are provided to those who need them most, with careful consideration of each individual's unique circumstances. Participants discussed the various reasons why providers face limitations on the services they can offer due to eligibility criteria. They agreed that resolving these issues is crucial to supporting effective reentry into the community. By addressing these eligibility challenges, providers will be better equipped to offer comprehensive services that meet the needs of reentering populations.	
Frequency:	*Determined by the state*	**Process Simplification and Discharge Planning:** Participants stressed the importance of making processes as straightforward as possible. They agreed that replicating an ideal model and avoiding unnecessary complexity would improve service delivery. Additionally, they highlighted that discharge planning should begin on day one and be viewed as an integral part of the transitional process, ensuring smooth reentry and continuity of care for individuals.	**Matching Frequency and Individual Needs:** Participants emphasized the need to align the frequency of services with where each youth is in their reentry journey. They stressed the importance of ensuring that youth receive the services they specifically need, with risk levels carefully assessed. Person-centered planning plays a critical role in this process, as different scenarios will dictate who provides the services and for how long. The group recognized that these variables would influence which support systems the youth fall into upon leaving the facility. They further highlighted that all youth should be considered part of a special population, with attention also given to supporting their families. Starting discharge planning on day one was again emphasized as essential for a smooth transition and continuity of care. Finally, participants noted that the service provider and the duration of services may vary once the youth leave the facility, depending on their needs and circumstances.
Duration:	*Up to 90 days pre-release, and at least 30 days post-release for eligible juveniles*	Participants recommended extending the pre-release period to a full 90 days for maximum flexibility in addressing individual needs. They also suggested that post-release services should last at least 90 days for maximum impact and continuity. Additionally, they proposed allowing an extension of up to 90 more days if further needs are identified.	Participants noted that clarification is needed from DYRS regarding the implementation of the 30- or 90-day mandate waiver option for providing services. This is particularly important when a child reaches stage 6 and remains on home petition for an extended period without clear insight into when they will be released. Understanding how to manage these transitions is crucial for the success of the case management process.

		The group discussed the need for some frequency adjustments based on individual circumstances but stressed the importance of keeping the process simple. They suggested limiting it to no more than two service levels, with a presumptive high-need designation to account for family and caregiver interactions. Discharge planning from day one remains critical for successful reentry, and participants emphasized that the more time spent with individuals post-release, the better the outcomes. For individuals with high levels of need, they recommended a minimum of six months of post-release support. Participants raised questions about the process when a provider or the individual's status changes: How is the information shared? Can services begin before the 90-day mark, or will 30 days be the norm? Additionally, participants stressed the importance of establishing a clear timeframe for tracking services post-release, with a threshold being essential. Having an individual's release date information is critical to know for service delivery. Sometimes the organization doesn't know that the individual is on parole. The more time the better to serve the individual (SSI applications or housing ex.). RSAT and some of the other programs can say who will be released within 90 days.	
Setting:	*Carceral*	*(Nothing was discussed during this session)*	*(Nothing was discussed during this session)*
Provider Staffing Qualifications:	*Can be either carceral or community-based provider. Qualifications for individual providers are determined by the state*	The group raised questions about who would be eligible to provide services. They emphasized the value of involving individuals with lived experiences in the work, as their insights could significantly enhance service delivery. However, participants also discussed concerns regarding background checks and whether these could prevent certain individuals from being involved in providing care. This consideration needs to be addressed to balance inclusion and compliance. This approach ensures continuity of services and relationships. Participants emphasized that using the same individuals for case management is essential for building trust. Agencies implementing	*(Nothing was discussed during this session)*

		this model will need community providers to begin case management services while individuals are still in custody.	
Staffing Ratio/ Caseload:	*Determined by the state*	*(Nothing was discussed during this session)*	*(Nothing was discussed during this session)*
Other Considerations:	*CMS has allowed flexibility for carceral and/or community-based providers to deliver this service (which gives the flexibility to build on existing case management services).*	It's important to consider the individual and family experience (e.g. non-duplication of services, limit possibility for diffusion of responsibility, enhance coordination) **Recommendations for Community Engagement:** • VSC recommended involving formerly incarcerated residents to discuss the services they would have found helpful, and she offered to coordinate these efforts. • OCA recommended forming a focus group of formerly incarcerated adults with psychiatric and intellectual disabilities and recruiting both current and former clients for interviews. Also highlighted need to compensate individuals with lived experience for their time and expertise	