Housing – 1115 Waiver Services Framework

- Questions:
  - Making sure there is building capacity
  - Adding this to current definition of medical respite
    - Housing itself to be a therapeutic pathway

	Example – California	*HSR – DC Proposal*
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 (and) behavioral health conditions.	DC's service description should consider: - The role of care coordination and linkage to social service supports and case management (e.g. housing), other medical services, and mental/behavioral health pathways; should be clear what the District intends to solve - Standard of care guidelines developed by respite organizations and the various medical support personnel needed to fulfill clinical standards - Beneficiary satisfaction with care (e.g. shared space vs private room), as well as the role of respite care in preventing beneficiary hospitalization
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.	Beneficiary eligibility should consider: - Respite care for families (the whole unit being housed together), pregnant, and immediately post-partum care needs - Those who have housing that would jeopardize their health and safety without modifications or those that don't have adequate housing for their health and safety, though this could be cost intensive to provide relative to providing service to those without any form of housing
Frequency:	As needed	As needed
Duration:	No more than 90 days in continuous duration	General interest in more than six months of care with intensive care management based on clinical standards and wrap around case management that provides pathways to long-term housing
Setting:	In-Person	In person setting to provide skilled nursing services and some medical treatment with options for specialty care or PCP visits via telehealth
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).	To be discussed in greater detail in subsequent meetings and with review of state best practices, current operations in the District, and state-based licensure guidelines
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	To be discussed in greater detail in subsequent meetings and with review of state best practices, current operations in the District, and state-based staffing guidelines

Other Considerations:		CMS allows up to a combined 6 months, once per year, with the time period assessed on a rolling basis.

Nutrition – 1115 Waiver Services Framework

Service Name:	Home delivered meals	Pantry stocking (delivered or for pick-up)	Fresh produce prescriptions/grocery provisions
Service Description:	- Medically-tailored vs. medically-supportive vs. nutritionally complete - Potential resource: https://www.mass.gov/doc/flexible-services-program-directory-2/download		- A Produce Prescription (PRx) Program is a medical treatment or preventative service for eligible patients due to diet-related health risks or conditions, food insecurity, or other documented challenges in access to nutritious foods, and are referred by a healthcare provider or health insurance plan. These prescriptions are fulfilled through food retail and enable patients to access healthy produce with no added fats, sugars, or salt, at low or no cost to the patient. When appropriately dosed, Produce Prescription Programs are designed to improve healthcare outcomes, optimize medical spending, and increase patient engagement and satisfaction.

Beneficiary Eligibility Criteria:	- For all nutrition services, need to consider what referral process might be
	  o Which z-codes (or other identifiers) are required to be documented in order to receive service?
	  o Are primary care providers (PCPs) involved in referral and/or service delivery?
	  o Assume that severe complex illness beneficiaries would need to be referred by medical professional
	- Other considerations and beneficiaries living conditions need to be considered, such as food shelf life, where beneficiary will store food, beneficiary access to kitchens and/or cookware
	- Eligibility should be based on severity or need
	- Need to create a list of eligible health conditions
	  o But also try to find a balance of not being too prescriptive to allow some flexibility and meet individual needs of beneficiaries		

Frequency:			
Duration:	- Look at Delaware as model of first providing home delivered meals before transitioning beneficiaries to pantry stocking		
Setting:			

Provider Staffing Qualifications:	- Potential resource: The Food Is Medicine Coalition (FIMC) Medically Tailored Meal (MTM) Intervention Accreditation Criteria and Requirements (ACR) https://fimcoalition.org/programs/fimc-accreditation - Which organizations provide services dictate what types of nutrition services are provided - Need to consider if food provision services need to be paired with nutritional counseling		
Staffing Ratio/ Caseload:			
Other Considerations:	- Evidence-based lifestyle programs that match a disease state and that already exist across the city (such as the diabetes prevention program) -Medicaid beneficiaries eligible for 1115 waiver nutrition services can include beneficiaries with: • Certain health risks • Nutrition-sensitive health conditions • Children or pregnant or postpartum beneficiaries and their households -CMS allows up to 3 meals/day for up to 6 months but intervention may be renewed for additional 6-month periods if the state determines the beneficiary still meets the clinical and needs-based criteria.		

Reentry – 1115 Waiver Services Framework

	CMS Requirements	*HSR – DC Proposal*
Service Name:	Targeted Case Management	Targeted Case Management Existing reentry case management services in the district **include, but are not limited to**: • DYRS case management • DOC (program - reentry case management, READY center in-reach, Medical discharge planning) • Voices for a Second Chance – case management program includes in-reach direct services in the DC Jail through through a 4-phase program and standard assessment tool • Other?
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 including at least one annual monitoring. See this link for further clarification on definitions	- Critical to highlight person-centered service delivery - Some disagreement on individuals who should provide services (outlined further in provider staffing qualifications section below) – led to conversation around the need to clearly establish the relationship between Medical and other behavioral health services and TCM – especially the assessment and reassessment (and differentiating the case management assessment from Medical and other behavioral health service assessments.
Beneficiary Eligibility Criteria:	All waiver beneficiaries must be provided TCM services, though the frequency and duration of services can vary based on identified need	
Frequency:	Determined by the state	
Duration:	Up to 90 days pre-release, and at least 30 days post-release for eligible juveniles	Services should take advantage of the full 90-day pre-release period
Setting:	Carceral	NOTE – Current discussion considering only DC Jail and DYRS facilities NOT BOP facilities

		Critical to deliver services in person in carceral setting where possible (telehealth helpful supplement – but currently not available in carceral setting for case management services)
Provider Staffing Qualifications:	Can be either carceral or community-based provider. Qualifications for individual providers are determined by the state	- Broad agreement across all stakeholders on leveraging individuals with lived experience and specific expertise in the carceral system to provide direct services given their ability to develop trust and expertise in navigating the system - Some indicated the need to consider having licensed clinical staff conduct assessment and reassessment and develop care plans and then lean on lived experience workforce to deliver further services though there was significant disagreement in the group with many individuals highlighting that non-licensed staff should be able to do all facets of targeted case management services - In consideration of operational barriers, should consider enrollment/credentialing and operational practices at the organizational rather than individual provider level (e.g. PSH and HH enrollment). - Concerns raised about the requirement for licensed provider supervision and the burden this may place on CBOs
Staffing Ratio/ Caseload:	Determined by the state	
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).	- Individual and family experience (e.g. non-duplication of services, limit possibility for diffusion of responsibility, enhance coordination) - Differences in needs and requirements for juvenile vs. adult population - Concerns about quality and thoroughness of services in carceral setting versus community. Persons may not share concerns completely to carceral staff. - Information sharing from carceral to community settings and vice versa to support continuity of care – while ensuring privacy and security considerations (both at the individual and policy level) - Lessons learned from MCP experience contracting with CBOs and with returning citizen work