Clinical Policy: Medical Respite Services

Reference Number: HI.CP.MP.507
Date of Last Revision: 2/26

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

This policy is to describe the clinical indications required for members of Ohana Health to receive medical respite services. Medical respite is not intended for members with high-acuity needs requiring intensive or specialized care. Instead, the benefit is designed for individuals who need short-term housing and support to prepare for or recover from a physical or mental health event.

Policy/Criteria

I. It is the policy of Ohana Health Plan that medical respite services are **medically necessary** when the following indications are met:

A. Member is homeless or at risk of homelessness as evidenced by one of the following:
   1. Member is at risk of homelessness as evidenced by one of the following indications:
      a. Has moved because of economic reasons two or more times during the sixty (60) days immediately preceding the application for homelessness prevention assistance;
      b. Is living in the home of another because of economic hardship;
      c. Has been notified in writing or verbally that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance;
      d. Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;
      e. Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;
      f. Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution);
      g. Lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the member's approved consolidated plan.
   2. Member is homeless and lacks a fixed, regular, and adequate nighttime residence, one of the following:
      a. Primary night-time residence is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground;
      b. Member lives in a supervised, publicly, or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state, or local government programs for low-income individuals);

c. Member is exiting an institution where they resided for ninety (90) days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution;
d. Will imminently lose their primary nighttime residence, all of the following:
   i. The primary nighttime residence will be lost within 21 days of the date of application for homeless assistance;
   ii. No subsequent residence has been identified;
   iii. Member lacks the resources or support networks, e.g., family, friends, faith-based or other social networks needed to obtain other permanent housing;
e. Member is an unaccompanied youth 18 to 25 years of age, or families with children and youth, who do not otherwise quality as homeless, all of the following:
   i. Have not had a lease, ownership interest, or occupancy agreement in permanent housing at any time during the 60 days immediately preceding the date of application for homeless assistance;
   ii. Have experienced persistent instability as measured by two moves or more during the 60-day period immediately preceding the date of applying for homeless assistance;
   iii. Can be expected to continue in such status for an extended period of time because of chronic disabilities, chronic physical health or mental health conditions, substance addiction, histories of domestic violence or childhood abuse (including neglect), the presence of a child or youth with a disability, or two or more barriers to employment, which include the lack of a high school degree or General Education Development (GED), illiteracy, low English proficiency, a history of incarceration or detention for criminal activity, and a history of unstable employment;
f. Member is fleeing, or is attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the individual or a family member, including a child, that has either taken place within the individual's or family's primary nighttime residence or has made the individual or family afraid to return to their primary nighttime residence;
g. Member has no other residence and lacks the resources or support networks, e.g., family, friends, faith-based or other social networks, to obtain other permanent housing.

B. Member has full decision-making capacity;
C. Member is able to live independently;
D. Member is independent with regard to activities of daily living (ADLs) and instrumental activities of daily living (IADLs), except for needing short-term assistance with regaining the ability to perform ADLs and IADLs as part of the recuperative process;
E. Member has an acute or chronic clinical issue that is likely to resolve, improve greatly, or stabilize through a medical respite stay.

II. It is the policy of Ohana Health Plan that medical respite services are considered **not medically necessary** when one or more of the following indications are met:
A. Member is not homeless or has no risk of homelessness;

B. Member has conditions that require services the medical respite provider site cannot support (this may vary by provider site and capacity);
C. Member requires medical help to take medications;
D. Member has incontinence that cannot be self-managed;
E. Member requires inpatient hospitalization for high-acuity behavioral health needs.

Note: Each medical respite benefit may be authorized for limited time periods, not to exceed a combined six months within a rolling 12-month period. The rolling 12-month period starts on the day that medical respite benefits begin.

Background

Medical Respite Services

Medical respite services (also referred to as "episodic interventions") provide eligible members short-term room and board with clinical services and other supports. Services are designed to support members with short-term needs to recover from or prepare for clinical events in safe, supportive housing. The benefit is not designed to meet members' long-term care needs. Medical respite services are time-limited based on clinical and social need. Health plans are responsible for monitoring benefit limits. If a member changes health plans, the former health plan is responsible for communicating the dates and length of any medical respite stays. In advance of January 1, 2026, the State may update the health plan change and transition of care file template (QI-2419A) to include basic information on medical respite benefit usage.
There are three distinct medical respite services:

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

Connection between Medical Respite and Housing Navigation Supports

Members can benefit from receiving both medical respite and housing navigation supports at the same time. For example, housing navigation supports can help members receiving medical respite to secure housing before the authorized medical respite period ends. Members may also request additional CIS+ services at any time if they are eligible. The CIS+ program encompasses two categories of benefits: housing navigation supports include both pre-tenancy support and tenancy sustaining services, while medical respite includes short-term pre-procedure housing, short-term recuperative care, and short-term post-hospitalization housing. All CIS+ services must be provided in a way that is culturally responsive and ensures meaningful access to language services.

All members receiving medical respite should be enrolled in housing navigation supports, unless they decline participation or are otherwise ineligible. Supportive Housing is an evidence-based practice that combines affordable housing with supportive services that help eligible individuals access housing resources and remain successfully housed. Members receiving short-term recuperative care or short-term post-hospitalization housing are automatically eligible for housing navigation supports. However, members receiving short-term pre-procedure housing are not automatically eligible; those receiving short-term pre-procedure housing may or may not have a complex behavioral or physical health need that would qualify them for housing navigation supports.

Any eligible member who is homeless or is at risk of becoming homeless can be referred for CIS+ screening to determine program eligibility. There are no restrictions on who can make the referral. Referrals should come from a variety of sources, including, but not limited to, self or family members, homeless services providers, other community-based organizations, and healthcare providers. The CIS+ eligibility criteria are intentionally broad to reduce barriers to services. Medicaid and CIS+ benefits are associated with individual members, not families. CIS+ benefit eligibility criteria include the following:

- Has a social risk factor (i.e., being homeless or at risk of homelessness);
- Has a clinical need (i.e., complex physical or mental health condition, and/or need for medical respite service).

Community Integration Services Plus (CIS+) – previously named Community Integration Services (CIS)— assists eligible members with becoming fully integrated members of the community as well as achieving improved health outcomes and life satisfaction. Effective January 1, 2026, the CIS+ program includes two types of housing-related benefits: housing navigation supports and medical respite. Members may also request additional CIS+ services at any time if they are eligible.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2025, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage.

Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description	Modifier
S5151	Unskilled respite care, not hospice; per diem	SC
S5151	Unskilled respite care, not hospice; per diem	SE
S9125	Respite care, in the home, per diem	22
S9125	Respite care, in the home, per diem	SC

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Policy created.	2/26	

References

1. State of Hawaii. Department of Human Services Med-QUEST Divisions. Community Integration Services Plus (CIS+) Implementation Updated Guidelines: Medical Respite-December 2025 Memorandum No. QI-2601 Update to QI-2314D; CCS-2601-Update to CCS-2303D. Received January 2, 2026. Accessed January 20, 2026.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.

Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.