ARIZONA | 2015

crosswalk

IMPROVING ACCESS TO MEDICAID BEHAVIORAL HEALTH SERVICES

For Arizona Medicaid Beneficiares Needing Supportive Housing

CSH
The Source for Housing Solutions

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Introduction

A small portion of individuals eligible for Medicaid in Arizona use a disproportionately high level of services. A subset of this population often exhibits complex chronic condition accompanied by behavioral health disorders. Furthermore, as signaled by their eligibility for Medicaid, these individuals often have incomes too low to afford market-rate housing. Through several frequent-users of health systems demonstration initiatives, CSH and partners have shown that supportive housing for homeless individuals with disabilities is cost effective. Inappropriate utilization of health services and associated costs are significantly minimalized when this population is in supportive housing. Supportive housing enables individuals with significant health needs to access and retain housing while connecting to services and achieve independence.

There are challenges to creating an adequate supply of supportive housing. Typically, housing development requires capital for acquisition and rehabilitation or new construction projects. Housing development also requires rental subsidies to cover operating costs. Operating subsidies are most often financed by U.S. Department of Housing and Urban Development (HUD) or through methods developed and administered by states, such as state rental subsidy or trust fund programs.

Medicaid reimbursement for behavioral health services in supportive housing and an uptick in housing subsidies are essential to serve individuals with complex chronic behavioral and physical health conditions. Arizona can achieve cost savings by ensuring appropriate utilization of health services, avoiding unnecessary ER visits and reducing inpatient hospitalization.

Arizona is fortunate to have Medicaid treatment, rehabilitation and support services available to persons in supportive housing. Thousands of persons with a determination of serious mental illness (SMI) are in supportive housing and receiving appropriate services to maintain independent community living. ***This is not the case for persons not determined to have a SMI, but nonetheless, suffer from chronic mental health and substance use conditions***. Access to programs and services offering housing subsidies and Medicaid behavioral health services for these individuals are often difficult to access. Medicaid, which provides free- or low-cost health coverage to low-income families, pregnant women and people with disabilities, may cover many services for tenants in supportive housing. However, the State of Arizona lacks specific policy directing contracted organizations to provide behavioral health services to non-SMI individuals needing supportive housing to achieve independence. Lack of policy direction for these services impedes and prevents the development of supportive housing.

As evidence continues to establish supportive housing as an intervention that stabilizes people with chronic illnesses, states are exploring ways to ensure Medicaid programs cover the services that supportive housing residents need. To this end, CSH has analyzed Arizona's Covered Behavioral Health Services Guide and accompanying documents to determine the extent to which Medicaid benefits extend to non-SMI Medicaid members living in supportive housing and offers recommendations to align state Medicaid policy and supportive housing services.

Supportive Housing is a SAMHSA Evidence-based Practice

Research shows supportive housing improves health outcomes and management of chronic conditions while reducing hospitalizations, ED visits, and Medicaid costs among homeless, high-cost beneficiaries. (Los Angeles FUSE Outcomes)

Lack of affordable housing and supportive services often results in low income people with behavioral and physical health issues cycling between jails, shelters, institutions and the streets. ***Supportive housing is a Substance Abuse and Mental Health Services Administration (SAMHSA) supported evidence based practice that combines permanent, affordable housing with flexible, voluntary and client centered support services designed to help the tenants stay housed and build the necessary skills to live as independently as possible.*** Supportive housing has been shown to achieve improved health outcomes and cost savings—particularly among populations who have proven to be high-cost, high-utilizers of multiple public systems of care[1].

The Evidence is Mounting A growing body of research shows that supportive housing can improve health and lower Medicaid and government-related costs for people who are highly vulnerable to negative health and social outcomes. By providing stable affordable housing, tenancy supports, and housing case management services that connect tenants to a network of comprehensive primary and behavioral health services, supportive housing can help improve health, foster mental health recovery, and reduce alcohol and drug use among formerly homeless individuals.

- A supportive housing project in Washington State, 1811 Eastlake, is nationally recognized for its documented success in improving health outcomes and reducing Medicaid costs by serving chronically homeless people in Seattle with severe alcoholism and high use of crisis services. A research study on the project was published in the Journal of the American Medical Association.[2] Ninety-five tenants of 1811 Eastlake had $8,175,922 in medical costs in the year prior to enrollment in the supportive housing project. In the year after enrollment, medical costs for these same individuals decreased 53% to $4,094,291.Total emergency costs for this sample declined by 73%, or nearly $600,000 in the two years after the program's launch. The project also found that supportive housing tenants dramatically reduced alcohol use within 12 months of tenancy (24% fewer drinks per day and 65% fewer days intoxicated).

- An Illinois supportive housing program identified a 39 % reduction in the total cost of services for 177 residents in the two years after moving into housing.[3] This figure includes services from Medicaid, mental health hospitals, substance use treatment centers, prisons and county jails, and hospitals. Mainstream service costs decreased by almost $5,000 per person for overall savings of $854,477 in two years for all participants. In Rhode Island, a cost study found that supportive housing led to a net savings per person per year of $8,839 after factoring the costs of both housing and services. Cost savings were realized as a result of reduced visits to emergency rooms and overnight stays in hospitals, mental health and chemical dependency treatment facilities, jails and prisons, and shelters.[4]

- The cost effectiveness of supportive housing is supported by multiple studies performed by communities nationally. For example, the Housing for Health Partnership in Chicago studied homeless individuals in inpatient hospitalization with chronic medical conditions. They found supportive housing saved Medicaid more than $22,000 per person, annually. In Massachusetts, a Housing First pilot for chronically homeless individuals demonstrated a savings of almost $9,000 per person in Medicaid costs per one year post-

[1] Nardone, Michael, Richard Cho, Kathy Moses. *Medicaid-Financed Services in Supportive Housing for High-Need Homeless Beneficiaries: The Business Case,* June 2012. Available at: http://www.csh.org/wp-content/uploads/2012/06/SH-Medicaid-Bz-Case_Final.pdf
[2] Larimer, et al., 2009
[3] Nogaski, Rynell, Terpstra, & Edwards, 2009
[4] Hirsch, Glasser, D'Addabbo, & Cigna, 2008

housing.[5] Finally, Maine researchers conducted a Medicaid cost analysis, illustrating savings of almost $5,000 per person, per year for those in supportive housing.[6]

Housing is critical to achieving positive health outcomes. A significant subset of Medicaid's high-need, high-cost beneficiaries experience homelessness and housing instability. For these individuals, homelessness exacerbates their chronic and complex conditions, increases their engagement in high-risk behaviors, and impedes their access to ongoing primary and preventive care, resulting in repeated hospitalizations, emergency department visits, and frequent use of other crisis services**.** Two recent supportive housing pilots targeting chronically homeless individuals in Maricopa County resulted in significant decreases in high cost health services and increased self-sufficiency:

- The Maricopa Frequent Users System Engagement (FUSE) pilot targeted 13 frequent users of St. Joseph's Hospital and Medical Center with the goal of decreasing inappropriate emergency room (ER) utilization and increasing self-sufficiency. All participants were single low income adults earning less than 133 percent of the Federal Poverty Level with histories of chronic homelessness, mental illness, and inappropriate, frequent use of emergency rooms and other costly crisis care. (The pilot began prior to Medicaid restoration; therefore, participants were not Medicaid beneficiaries at the inception but became eligible over time).

  Over 24 months, participants were provided supportive housing and linked to comprehensive, coordinated health, mental health, addiction, and wrap-around services in the community. Since inception, ***94% of participants have retained their housing. An independent evaluation determined that FUSE decreased participant ER visits 73.8%, ER costs 74.7%, hospital in-patient days 47.2% and in-patient costs 36.6%.*** Participants also improved economic self-sufficiency by almost 6 standard deviations as measured by the Arizona Self Sufficiency Matrix (SSM).

- The Tempe Pilot was initiated in 2010 by the City of Tempe, Valley of the Sun United Way, CSH and other community partners in order to demonstrate the efficacy of supportive housing. The pilot targeted 35 chronically homeless individuals in the City of Tempe, including 19 seriously mentally ill persons who were enrolled in Magellan Healthcare. All participants were provided supportive housing with client centered, voluntary services. An independent evaluation determined that after three years, ***89% of pilot participants maintained their housing. In addition, 31% completely eliminated ER visits and the average costs of emergency and outpatient services were reduced by nearly 80%*** [7]**.**

Many of the services needed by people in supportive housing are covered under Arizona's Medicaid program, and are aligned with health reform's movement toward a more coordinated and person-centered approach to health care delivery.

[5] Nogaski, Rynell, Terpstra, & Edwards, 2009

[6] Hirsch, Glasser, D'Addabbo, & Cigna, 2008

[7] http://vsuw.org/files/A_Path_to_End_Homelessness_sm.pdf

Supportive Housing Services in the United States and Arizona Today

Across the United States, services in supportive housing are generally funded through a mix of federal, state, and private grants. HUD is the largest funder of permanent supportive housing. HUD has increased funding for housing, prioritized new housing for people experiencing chronic homelessness, and evaluated local funding bodies called 'continua of care' for their ability to leverage public and private funding sources. For nearly a decade, HUD has strongly encouraged its grantees to integrate mainstream resources, which are community programs or resources that are not specifically designated for people who are homeless, but for which homeless persons likely are eligible.

While services for individuals with SMI are funded through the Regional Behavioral Health Authorities and significant HUD grants, services for individuals not determined to have a SMI vary. Furthermore, unlike many states, Arizona does not invest general funds for services in supporting housing for non-SMI populations.

Throughout Arizona, supportive housing programs collaborate with local agencies to maximize access to services in housing. Gaps in services are prevalent. Supportive housing providers must engage in private fundraising efforts to close gaps, which jeopardize the success of tenants. Lack of resources also prevents the growth of supportive housing, which has proven to end homelessness for the most vulnerable homeless populations.

Persons determined to have a SMI may access a variety of housing options and support services through the Division of Behavioral Health Services T/RBHAs. Programs to support independent living include rent subsidy and supported housing programs; bridge subsidy housing assistance while obtaining federal funding; and provider owned or leased homes and apartment complexes that combine housing services with other covered behavioral health services. Similarly, T/RBHA housing programs include rent subsidy programs, owner occupied home repairs, move-in assistance and eviction prevention programs coupled with needed supported housing services to maintain independent living.

The behavioral health system does not fund supportive housing for individuals with significant behavioral health issues that do not rise to the level of SMI, but are often accompanied by complex chronic conditions and substance use disorders.These individuals are not well served by existing programs due to the lack of housing and services to support independent living. These same individuals also pose a significant challenge to health and emergency care systems due to repeated and inappropriate use of costly and sometimes limited services.

Homelessness, especially over long periods, is extremely isolating and excludes the people experiencing it from society.

Olmstead and its Impact on Adults with Chronic Homelessness, Mental Health, and Substance Use Conditions

The Supreme Court's Olmstead decision mandates that states eliminate unnecessary segregation of persons with disabilities and to ensure that persons with disabilities receive services in the most integrated setting appropriate to their needs. In addition to addressing the needs of people with disabilities that have been inappropriately institutionalized, the Olmstead decision also ruled that unjustified isolation is discrimination based on disability.[8] These individuals often cycle through institutionalized settings, such as nursing homes, jails or mental health hospitals, by virtue of their disability and their homelessness. As the Olmstead decision recognized, shelters are inappropriate settings as people living in shelters are warehoused in congregate settings, often for long periods.

Supportive housing allows people with disabilities to live independently in apartments integrated into the community.[9] Tenants have the opportunity to connect to and thrive in the community and to reconnect with family members and friends. The combination of safe, decent, affordable housing with voluntary supports provides a solid foundation for people to live independently and thrive in our communities. In order to implement its Olmstead plan, the State of Arizona must increase the supply of supportive housing. The Medicaid program, specifically financing services in housing, is necessary in order to fulfill the Olmstead plan, ensuring that individuals have access to services necessary to acquire and maintain housing.[10]

Behavioral Health Treatment, Rehabilitation and Support Services are Covered in Many Settings

Recent crosswalk analyses of supportive housing programs suggest that as much as 60% of services provided in a supportive housing environment are potentially reimbursable under the Medicaid program.[11] The extent of service alignment with Medicaid benefits varies by state. ***As the chart in Attachment #1 illustrates, an overwhelming majority of services necessary for stability in supportive housing are included in Arizona's Medicaid program*** for those individuals who are eligible for AHCCCS and diagnosed with a behavioral health condition.

It is important to note that Arizona includes a unique Supported Housing covered service, although not reimbursed through Medicaid. The Supported Housing service includes services provided in an independent community setting, including home-based, that are necessary to maintain housing. Rent and utility subsidies are allowable services. These funds may not be spent on:

- Meals, furnishings, telephone usage/fees, or other household equipment
- Direct payment to the individual or the family, or
- Residential treatment room and board charges.

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[8] Olmstead at 593

[9] Olmstead at 600

[10] *Supportive Housing & Olmstead: Creating Opportunities for People with Disabilities.* Corporation for Supportive Housing, November 2012. Available at: *http://www.csh.org/wp-content/uploads/2012/12/Supportive_Housing_Olmstead.pdf*

[11] *Implementation of the Affordable Care Act and Medicaid Reform in Illinois to Incorporate Permanent Supportive Housing*. Corporation for Supportive Housing; Heartland Alliance; Health and Disability Advocates, August 2011. Available at: http://www.csh.org/resources/implementation-of-the-affordable-care-act-and-medicaid-reform-in-illinois

Recommendations

Arizona has a long history of covering services that enable individuals with behavioral health issues to achieve independence and self- sufficiency. There are, however, barriers to accessing these services for many individuals whose behavioral and physical health conditions prove a challenge to obtaining and maintaining stable and independent housing. These challenges must be addressed in order to maximize cost and health outcomes, especially as the State of Arizona moves to a system of coordinated and integrated care for its most costly and vulnerable populations.

1. Evaluate usage of Arizona's supportive housing program and services provided to Medicaid beneficiaries. Consider program improvement opportunities and barriers to gaining access to needed covered services for persons <u>not</u> determined to have a SMI, but nonetheless, suffer from chronic mental health and substance use conditions.

2. The Crosswalk illustrates allowable services under Arizona's Medicaid program. Consider maintaining rent and utilities benefits as a state-only service and creating a new Medicaid per diem rate for a supportive housing for individuals who require supportive housing (H0043, supportive housing, per diem). The benefit would offer a case rate payment to supportive housing service providers who would offer services in housing to these high-acuity beneficiaries.

3. Enable supportive housing providers to bill Medicaid for services as Community Services Agencies (CSA) as defined by the Arizona Department of Health Services, Division of Behavioral Health Services. CSAs provide services that enhance or supplement behavioral health services that persons receive through other, licensed agencies In order to adequately fund services.

4. Develop partnerships between providers of supportive housing and behavioral health providers that can bill Medicaid for services in supportive housing. The State of Arizona should consider supportive housing providers as partners in a coordinated care approach to behavioral and physical health care service delivery and integrate them into the service delivery system.

5. As Medicaid expansion is implemented, identify ways to target supportive housing services to high need and high cost populations including homeless individuals with chronic health conditions, co-occurring disorders, tri-morbidities, repeated emergency room visits and/or inpatient hospital stays.

ARIZONA SUPPORTIVE HOUSING MEDICAID CROSSWALK

EXPLANATION OF SUPPORTIVE HOUSING SERVICES				ADHS/DBHS CONTINUUM OF SERVICES DOMAINS FROM COVERED BEHAVIORAL HEALTH SERVICES GUIDE (CBHSG)				
Supportive Housing Service Category	**Supportive Housing Service Component**	**Supportive Housing Service Component Stakeholder Definition**	**Medicaid Service Component Description (this helps translate for Medicaid if needed)**	**Treatment Services**	**Rehab Services**	**Medical Services**	**Support Services**	**Crisis Intervention Services**
Tenancy Supports	Finding Housing	Determine appropriate type and location for housing; search for housing	Case Management - Assistance in finding necessary resources other than covered services to meet basic needs				CBHSG II.D.1 - HCPCS T1016 HO; in and out-of-office by BHP; or T1016-HN in and out-of-office by BHT or BHP	
	Applying for Housing	Secure documents necessary for rental assistance	Case Management - Assistance in finding necessary resources other than covered services to meet basic needs				CBHSG II.D.1 - HCPCS T1016-HO; in and out-of-office by BHP; or T1016-HN in and out-of-office by BHT or BHP	
	Landlord advocacy	Fostering and maintaining relationship with landlords	Skills Training and Development and Psychosocial Rehabilitation Living Skills Training. Examples of areas that may be addressed include self-care, household management, social decorum, same-and opposite-sex friendships, avoidance of exploitation, budgeting, recreation, development of social support networks and use of community resources.		CBHSG II.B.1 - HCPCS H2014, H2014 HK, H2014 HQ, H2017, some billing restrictions, use H2014 if <8 hours, H2017 if > 8 hours.			

Tenancy Supports (cont'd)	Securing household supplies, furniture	New tenant orientation and move-in assistance	Case Management - Assistance in finding necessary resources other than covered services to meet basic needs				CBHSG II.D.1 - HCPCS T1016 HO; in and out-of-office by BHP; or T1016-HN in and out-of-office by BHT or BHP	
	Tenancy supports and eviction prevention	Good neighbor skills; Problem solving around household maintenance; Promoting housekeeping , cleanliness, bug control, Managing substance use	Skills Training and Development and Psychosocial Rehabilitation Living Skills Training. Examples of areas that may be addressed include self-care, household management, social decorum, same-and opposite-sex friendships, avoidance of exploitation, budgeting, recreation, development of social support networks and use of community resources.		CBHSG II.B.1 - HCPCS H2014, H2014 HK, H2014 HQ, H2017, some billing restrictions, use H2014 if <8 hours, H2017 if > 8 hours.			
	Rental Assistance and financial management	Communication with landlord & neighbors, managing external relationships that effect housing	Skills Training and Development and Psychosocial Rehabilitation Living Skills Training. Examples or areas that may be addressed include self-care, household management, social decorum, same-and opposite-sex friendships, avoidance of exploitation, budgeting, recreation, development of social support networks and use of community resources.		CBHSG II.B.1 - HCPCS H2014, H2014 HK, H2014 HQ, H2017, some billing restrictions, use H2014 if <8 hours, H2017 if > 8 hours.			
	Connect individuals with mainstream services	Work with client to determine needs and appropriate services; connect individuals with mainstream services that match their needs	Case Management - Assistance in finding necessary resources other than covered services to meet basic needs				CBHSG II.D.1 - HCPCS T1016 HO; in and out-of-office by BHP; or T1016-HN in and out-of-office by BHT or BHP	

Outreach and in-reach services	Respite Care	Care after hospital discharge but before or in between housing	Not covered					
	Discharge Planning	Discharge planning & coordinating with outside care providers	Case Management - Brief telephone or face-to-face interactions with a person, family or other involved party for the purpose of maintaining or enhancing a person's functioning; Assistance in finding necessary resources and other than covered services to meet basic needs; Communication and coordination of care with the person's family, behavioral and general medical and dental health care providers, community resources, and other involved supports including educational, social, judicial, community and other State agencies; Coordination of care activities related to continuity of care between levels of care (e.g. inpatient to outpatient care) and across multiple services (e.g., personal assistant nursing services and family counseling); Participation in staffing, case conferences or other meetings with or without the person or their family participating; Other activities as needed.				CBHSG II.D.1 - HCPCS T1016 HO; in and out-of-office by BHP; or T1016-HN in and out-of-office by BHT or BHP	

Outreach and in-reach services (cont'd)	Reengagement	Engage homeless, disabled person; build trusting relationship; case management services provided on demand or as needed	Case Management - Assistance in finding necessary resources other than covered services to meet basic needs				CBHSG II.D.I - HCPCS T1016 HO; in and out-of-office by BHP; or T1016-HN in and out-of-office by BHT or BHP	
	Identifying and engaging with un-served, underserved, and poorly served individuals	Determine immediate safety needs (cold weather, medication, mental/physical); case management services available outside of traditional offices, such as on the streets, in shelters	Prevention -Not covered by Medicaid. Other funds such as SAPT or state funds, as available, non-encounterable.					
Assessment, Case Management or Service Coordination	***Assessment***							
	Services intake		Assessment - Gathering and assessment of historical and current information which includes face-to-face contact with the person and/or the person's family or other informants, or group of individuals resulting in a written summary report and recommendations.	CBHSG II.A.2 - Numerous CPT codes; HCPCS H0001, H0002, H0031 and H0031 HK. Regarding an assessment by a housing specialist, H0031 MH Assessment by				
	Assessment - Identifying Client Needs							
	Gathering required documentations for eligibility determinations							
	Arranging for further testing and evaluation							
	Conducting reassessments							

Assessment, Case Management or Service Coordination (cont'd)	Documenting assessment activities			Non-Physician is ADHS/DBHS credentialed behavioral health professionals and behavioral health techs with appropriate supervision may be used.				
	Service Plan Development							
	Service Plan Development with client/tenant		Case Management - Participating in staffing, case conferences or other meetings with or without the person or their family participating				CBHSG II.D.1 - HCPCS T1016 HO; in and out-of-office by BHP; or T1016-HN in and out-of-office by BHT or BHP	
	Determine who should provide services		Case Management - Assistance in maintaining, monitoring and modifying covered services				CBHSG II.D.1 - HCPCS T1016 HO; in and out-of-office by BHP; or T1016-HN in and out-of-office by BHT or BHP	
	Update & review service plan		Case Management - Participation in staffing, case conferences or other meetings with or without the person or their family participating.				CBHSG II.D.1 - HCPCS T1016 HO; in and out-of-office by BHP; or T1016-HN in and out-of-office by BHT or BHP	
	Referral, Monitoring, Follow-up							
	Referrals and related activities		Case Management - Assistance in maintaining, monitoring and				CBHSG II.D.1 - HCPCS T1016 HO; in and out-of-	

Assessment, Case Management or Service Coordination (cont'd)	Referrals to other ancillary services		modifying covered services				office by BHP; or T1016-HN in and out-of-office by BHT or BHP	
	Assist in connecting to services		Case Management - Assistance in maintaining, monitoring and modifying covered services;				CBHSG II.D.1 - HCPCS T1016 HO; in and out-of-office by BHP; or T1016-HN in and out-of-office by BHT or BHP	
	Coordination of services identified in service plan		Case Management - Coordination of care activities related to continuity of care between levels of care (e.g. Inpatient to outpatient care) and across multiple services (e.g. personal assistant, nursing services and family counseling)				CBHSG II.D.1 - HCPCS T1016 HO; in and out-of-office by BHP; or T1016-HN in and out-of-office by BHT or BHP	
	Monitoring and Evaluation		Case Management - Participation in staffing, case conferences or other meetings with or without the person or their family participating.				CBHSG II.D.1 - HCPCS T1016 HO; in and out-of-office by BHP; or T1016-HN in and out-of-office by BHT or BHP	
	Personal Advocacy		Case Management - Assistance in maintaining, monitoring and modifying covered services; Outreach and follow-up of crisis contacts and missed appointments.				CBHSG II.D.1 - HCPCS T1016 HO; in and out-of-office by BHP; or T1016-HN in and out-of-office by BHT or BHP	

Assessment, Case Management or Service Coordination (cont'd)	Case manager accompaniment on appointments		Case Management - Communication and coordination of care with the person's family, behavioral and general medical dental health care providers, community resources and other involved supports including education, social, judicial, community and other State agencies.				CBHSG II.D.1 - HCPCS T1016 HO; in and out-of-office by BHP; or T1016-HN in and out-of-office by BHT or BHP	
Transportation	Transportation		Non-Emergency Transportation - Transportation services involve the transporting of a person from one place to another to facilitate the receipt of, or benefit from, medically necessary covered BH services, allowing the person to achieve their service plan goals.				CBHSG.II.D.10	
Independent living skills training	Nutrition Education		Skills Training and Development and Psychosocial Rehabilitation Living Skills Training. Examples of areas that may be addressed include self-care, household management, social decorum, same-and opposite-sex friendships, avoidance of exploitation, budgeting, recreation, development of social support networks and use of community resources.		CBHSG II.B.1 - HCPCS H2014, H2014 HK, H2014 HQ, H2017, some billing restrictions, use H2014 if <8 hours, H2017 if > 8 hours.			
	Individual Counseling							
	Personal hygiene and self-care							
	Housekeeping							
	Apartment safety							
	Using public transportation							
	Cooking/meal prep							
	School Connections							

Job skills training / education	Access to Academic Support		Case Management - Communication and coordination of care with the person's family, behavioral and general medical dental health care providers, community resources and other involved supports including education, social, judicial, community and other State agencies.				CBHSG II.D.1 - HCPCS T1016 HO; in and out-of-office by BHP; or T1016-HN in and out-of-office by BHT or BHP	
	Opportunities/access to GED, post-secondary training							
	Supported Employment		Psycho educational Service (Pre-Job Training and Job Development) and ongoing Support to Maintain Employment (Job Coaching and Employment Support)		CBHSG II.B.4 HCPCS H2027, H2025, H2026			
	Connections to childcare resources		Case Management - Assistance in finding necessary resources other than covered services to meet basic needs.				CBHSG II.D.1 - HCPCS T1016 HO; in and out-of-office by BHP; or T1016-HN in office by BHT or BHP	
Domestic violence Intervention	Crisis Planning		Case Management - Outreach and follow-up of crisis contacts and missed appointments.				CBHSG II.D.1 - HCPCS T1016 HO; in and out-of-office by BHP; or T1016-HN in office by BHT or BHP	

Domestic violence Intervention (Cont'd)	Crisis Intervention Services, mobile or community based		Crisis Intervention Services - Services are provided by a mobile team or individual who travels to the place where the person is having the crisis. Crisis intervention services include services aimed at the assessment and immediate stabilization of acute symptoms of mental illness, alcohol and other drug abuse, and emotional distress. The purpose of the services it to stabilize, evaluate treatment needs, and develop plans to meet the persons need.					CBHSG II.E.1. H2011 and H2011 HT
	Child Protection assessment, follow up		Case Management - Assistance in finding necessary resources other than covered services to meet basic needs				CBHSG II.D.1 - HCPCS T1016 HO; in and out-of-office by BHP; or T1016-HN in office by BHT or BHP	
	Training in personal and household safety		Skills Training and Development and Psychosocial Rehabilitation Living Skills Training (see previous definitions under 'Independent Living Skills.'		CBHSG II.B.1 - HCPCS H2014, H2014 HK, H2014 HQ, H2017, some billing restrictions, use H2014 if <8 hours, H2017 if > 8 hours.			

Behavioral Health	Substance abuse counseling		Behavioral Health Counseling and Therapy is an interactive therapy designed to elicit or clarify presenting and historical information, identify behavioral problems or conflicts and provide support and education or understanding for the person group or family to resolve or manage the current problem or conflict and prevent resolve or manage similar future problems or conflicts.	CBHSG II.A.I Numerous CPT codes, H0004, HR, HS, HQ				
	Peer counseling, mentoring and support		Self-Help/Peer Services (Peer Support)				CBHSG II.D.4 H0038, HQ (15 min) and H2016 (per diem)	
	Education about mental illness		Behavioral Health Prevention/Promotion Education and Medication Training and Support Services (Health Promotion)		CBHSG II.B.3 H0025			
	Psychotropic medication		Medication Services prescribed by a licensed physician, nurse practitioner or physician assistant to prevent, stabilize or ameliorate symptoms arising from a behavioral health condition or its treatment.			CBHSG II.C.1. several CPT codes for injections. NDC codes must be used for all prescribed medications dispensed by a pharmacy.		

Behavioral Health (cont'd)	Medication Education		Behavioral Health Prevention/Promotion Education and Medication Training and Support Services (Health Promotion)		CBHSG II.B.3 H0034			
	Recovery readiness		Self-Help/Peer Services (Peer Support)				CBHSG II.D.4 H0038, HQ (15 min) and H2016 (per diem)	
	Harm Reduction strategies		Skills Training and Development and Psychosocial Rehabilitation Living Skills Training (see previous definitions under 'Independent Living Skills.'		CBHSG II.B.I - HCPCS H2014, H2014 HK, H2014 HQ, H2017, some billing restrictions, use H2014 if <8 hours, H2017 if > 8 hours.			
	Relapse prevention		Behavioral Health Prevention/Promotion Education and Medication Training and Support Services (Health Promotion)		CBHSG II.B.3 H0025			
	Recreation		Skills Training and Development and Psychosocial Rehabilitation Living Skills Training (see previous definitions under 'Independent Living Skills.'		CBHSG II.B.I - HCPCS H2014, H2014 HK, H2014 HQ, H2017, some billing restrictions, use H2014 if <8 hours, H2017 if > 8 hours.			

Social Health and Recovery	Grief Counseling		Behavioral Health Counseling and Therapy is an interactive therapy designed to elicit or clarify presenting and historical information, identify behavioral problems or conflicts and provide support and education or understanding for the person group or family to resolve or manage the current problem or conflict and prevent resolve or manage similar future problems or conflicts.	CBHSG II.A.I Numerous CPT codes, H0004, HR, HS, HQ		-		
	Development of Recovery Plans		Self-Help/Peer Services (Peer Support)				CBHSG II.D.4 H0038, HQ (15 min) and H2016 (per diem)	
	Group Therapy		Behavioral Health Counseling and Therapy	CBHSG II.A.I 90853, H0004 HQ				
	Social Support		Skills Training and Development and Psychosocial Rehabilitation Living Skills Training (see previous definitions under 'Independent Living Skills.'		CBHSG II.B.I - HCPCS H2014, H2014 HK, H2014 HQ, H2017, some billing restrictions, use H2014 if <8 hours, H2017 if > 8 hours.			
	Community Involvement/Integration		Skills Training and Development and Psychosocial Rehabilitation Living Skills Training (see previous definitions under 'Independent Living Skills.'		CBHSG II.B.I - HCPCS H2014, H2014 HK, H2014 HQ, H2017, some billing restrictions, use H2014 if <8 hours, H2017 if > 8 hours.			

Social Health and Recovery (cont'd)	Parenting supports and mentoring		Behavioral Health Prevention/Promotion Education (Health Promotion) Education and training to families related to the enrolled persons treatment plan with the purpose of increasing an individual's behavioral knowledge such as parenting skills education and healthy lifestyles.		CBHSG II.D.I - H0025			
	Conflict Resolution/ mediation training		Skills Training and Development and Psychosocial Rehabilitation Living Skills Training (see previous definitions under 'Independent Living Skills.'		CBHSG II.B.I - HCPCS H2014, H2014 HK, H2014 HQ, H2017, some billing restrictions, use H2014 if <8 hours, H2017 if > 8 hours.			
Financial and other benefits assistance	Application assistance		Case Management - Assistance in maintaining, monitoring and modifying covered services				CBHSG II.D.I - HCPCS T1016 HO; in and out-of-office by BHP; or T1016-HN in and out-of-office by BHT or BHP	
	Entitlement and benefits counseling		Case Management - Assistance in finding necessary resources other than covered services to meet basic needs;				CBHSG II.D.I - HCPCS T1016 HO; in and out-of-office by BHP; or T1016-HN in and out-of-office by BHT or BHP	

Financial and other benefits assistance (cont'd)	Referral to legal advocacy and assistance with appeals when needed to appeal a denial of public benefits		Case Management - Assistance in maintaining, monitoring and modifying covered services				CBHSG II.D.I - HCPCS T1016 HO; in and out-of-office by BHP; or T1016-HN in and out-of-office by BHT or BHP	
	Budgeting and financial education		Skills Training and Development and Psychosocial Rehabilitation Living Skills Training (see previous definitions under 'Independent Living Skills.'		CBHSG II.B.I - HCPCS H2014, H2014 HK, H2014 HQ, H2017, some billing restrictions, use H2014 if <8 hours, H2017 if > 8 hours.			
Routine medical care, medication management, vision, dental, HIV/AIDS services	Health Care Coordination - overall		Case Management - Coordination of care activities related to continuity of care between levels of care (e.g., inpatient to outpatient care) and across multiple services (e.g. personal assistant, nursing services and family counseling)				CBHSG II.D.I - HCPCS T1016 HO; in and out-of-office by BHP; or T1016-HN in office by BHT or BHP	
	Medication coordination		Medical Management - Assessment and management services that are provided by a licensed medical professional to a person as part of their medical visit for ongoing treatment purposes. Includes medication services involving the review of the effects and side effects of medications and the adjustment of the type and dosage of prescribed medications.		CBHSG II.C.3 - Numerous CPT codes, T1002 RN services and T1003 LPN services			
	HIV/AIDS/STD Education		Behavioral Health Prevention/Promotion Education and Medication Training and Support Services (Health Promotion)		CBHSG II.B.3 H0025			

Routine medical care, medication management, vision, dental, HIV/AIDS services (cont'd)	End of life planning		Case Management - Coordination of care activities related to continuity of care between levels of care (e.g., inpatient to outpatient care) and across multiple services (e.g. personal assistant, nursing services and family counseling) Participation in staffing, case conferences or other meetings with or without the person or their family participating				CBHSG II.D.I - HCPCS T1016 HO; in and out-of-office by BHP; or T1016-HN in and out-of-office by BHT or BHP	

<u>Definitions - Categories of Services (COS)</u>

II.A. Treatment services are provided by or under the supervision of behavioral health professionals to reduce symptoms and improve or maintain functioning. These services are further grouped into the following categories:

- Behavioral Health Counseling and Therapy
- Assessment, Evaluation and Screening Services
- Other Professional

II.B. Rehabilitation Services include the provision of education, coaching, training, and demonstrating. Other services include securing and maintaining employment to remediate residual or prevent anticipated functional deficits. Except for cognitive rehabilitation, which is billed using a CPT code, rehabilitation services are billed using HCPCS codes. Rehabilitation services include the following:

- Skills Training and Development and Psychosocial Rehabilitation and Living Skills Training
- Cognitive Rehabilitation
- Behavioral Health Prevention/Promotion Education and Medication Training and Support (Health Promotion)
- Psycho educational Service (Pre-Job Training and Job Development) and Ongoing Support to Maintain Employment (Job Coaching and Employment Support)

II.C. Medical Services are provided or ordered by a licensed physician, nurse practitioner, physician assistant, or nurse to reduce a person's symptoms and improve or maintain functioning. These services are further grouped into the following categories:

- Medication
- Laboratory, Radiology and Medical Imaging
- Medical Management (including medication management)
- Electroconvulsive Therapy (ECT)

II. D. Support Services are provided to facilitate the delivery of or enhance the benefit received from other behavioral health services. These services have been grouped into the following categories:

- Case Management
- Personal Care Services
- Home Care Training Family Services (Family Support)
- Self-Help/Peer Services (Peer Support)
- Home Care Training to Home Care Client (HCTC)
- Unskilled Respite Care
- Supported Housing
- Sign Language or Oral Interpretive Services
- Non-Medically Necessary Covered Services (Flex Fund Services - Non-Medicaid)
- Transportation

II.E. Crisis Intervention Services are provided to a person for the purpose of stabilizing or preventing a sudden, unanticipated, or potentially dangerous behavioral health condition, episode or behavior. Services vary and many types of covered behavioral health services may be provided when providing crisis intervention services (screening, counseling and therapy, case management). All services billed must be identified by entering emergency indicators. Other specific crisis services include:

- CPT codes 99281, 99282, 99283, 99284, 99285,
- Crisis Intervention Services - Mobile, Community Based
- Crisis Intervention Services - Stabilization, facility based
- Crisis Intervention (telephone)

Addendum #1
Additional Information and Rate Setting Approach
Supportive Housing
June 2015

I. Introduction

CSH in Arizona recently completed the report **Improving Access to Medicaid Behavioral Health Services for Arizona Medicaid Beneficiaries Needing Supportive Housing** and an accompanying **Supportive Housing Services and Medicaid Crosswalk.** The report provides clear evidence that supportive housing services provided to Medicaid members can decrease healthcare spending while improving the quality of life for members. The Crosswalk identifies covered services that are currently available, but not always accessed for members needing supportive housing services. The report offered six recommendations to improve availability and access to supportive housing services to Medicaid members with complex medical conditions accompanied by behavioral health conditions, regardless of whether a person has been determined to have a serious mental illness. Recommendation 2 states:

> "*2. The Crosswalk illustrates allowable services under Arizona's Medicaid program. Consider maintaining rent and utilities benefits as a state-only service and creating a new Medicaid per diem rate for a supportive housing for individuals who require supportive housing (H0043, supportive housing, per diem). The benefit would offer a case rate payment to supportive housing service providers who would offer services in housing to these high-acuity beneficiaries.*

This addendum is intended to provide additional information about supportive housing providers and the services they provide as well as identify an approach to setting alternative Medicaid rate(s) for supportive housing services provided by SH and behavioral health providers.

II. Current Status

There are two codes that are frequently used by states to provide supportive housing as a distinct service: H0043, Supported Housing (per diem) and H0044, Supported Housing (per month). The ADHS/DBHS Covered Service Guide (October 1, 2014 edition) lists H0043, Supported Housing, as a covered service. The general definition provided in the Covered Service Guide is as follows:

> *"Supported housing services are provided to assist individuals or families to obtain and maintain housing in an independent community setting including the person's own home or apartments and homes owned or leased by a subcontracted provider. These services may include rent and utility subsidies, and relocation services to a person or family for the purpose of securing and maintaining housing."*

CSH understands *that ADHS/DBHS, RBHAs and behavioral health providers use H0043 to provide and bill for Non-Medicaid covered services, almost exclusively for rent and utility subsidies for persons with SMI who need supportive housing services*. Additional Medicaid covered services *can and are* provided using a variety of other Medicaid covered services and billed individually. CSH has identified several existing codes that are covered by AHCCCS and ADHS/DBHS to support people needing supportive housing: T1016, H2014, H2017,

H0001, H0002, H0031, H2025, H2026, H2027, H2011, H0004, H0038, H2016, H0034, H0025, T1002, and T1003 along with additional counseling and medication services codes.

The following table lists these services, codes, current rate and population served as used Arizona:

Service Title	Service Code (HCPCS)	AHCCCS/BH Covered Service?	BH State Funded Covered Service?	ADHS/DBHS Allowable Procedure Code Matrix Current Rate	Populations Served
Supported Housing Per Diem	H0043	No	Yes	$20.02	Should be all adults, but usually for persons with SMI
Supported Housing Per Month	H0044	No	No	N/A	N/A

States have used H0043 and H0044 provide and bill Medicaid services such as community living supports; rather than just rent and utilities as a state-only service. For example, Florida Medicaid uses H0044, Supported Housing per month, to cover services from mental health staff to people living independently in supported housing.[1]

III. Rate Setting Approach for Medicaid Supportive Housing Services

CSH recommends that AHCCCS and ADHS/DBHS consider a definition and rate review of H0043 and/or establish a definition and rate for H0044 to expand the supportive housing definition and current ADHS/DBHS rate to be more inclusive of what supportive housing (SH) services involves (case management, living skills, etc.) and determine the most appropriate unit of service (hourly, per diem, per month). This could be result in a new "bundled" rate for supportive housing services; a concept that is gaining more and more ground in healthcare financing. CSH would like to see the continuation of the rental subsidy as a state-funded covered service. We see three steps involved to get the information needed to set a rate:

- **Step 1**: Additional information on supportive housing providers, their numbers, how they deliver supported housing services (which is included in the sub-section below). The State should consider identifying supported housing expenditures from encounters and other reports.

[1] [1]Florida, DCF Pamphlet 4: H0044: SUPPORTED HOUSING PER MONTH
Services to assist individuals in finding and maintaining appropriate housing arrangements. This activity is premised upon the idea that certain clients are able to live independently in the community only if they have support staff for monitoring and/or assisting with residential responsibilities. These staff assist clients to select, obtain, and maintain safe, decent, affordable housing and maintain a link to other essential services provided within the community. The objective of supported housing is to help obtain and maintain an independent living situation. Supported Housing is a specific program model in which a consumer lives in a house, apartment or similar setting, alone or with others, and has considerable responsibility for residential maintenance but receives periodic visits from mental health staff or family for the purpose of monitoring and/or assisting with residential responsibilities, criteria identified for supported housing programs include: housing choice, functional separation of housing from service provision, affordability, integration (with persons who do not have mental illness), right to tenure, service choice, service individualization and service availability.

- **Step 2**: Provider survey to gather explicit data and cost on how supportive housing services are currently delivered (examples of what might be included in a provider survey are also included below)
- **Step 3**: Establishing a value-based rate(s) using provider submitted data and independent data (such as Bureau of Labor Statistics data and other nationally excepted rates normed for Arizona). There are at least three possible rates:
    a. Review H0043, per diem, for its adequacy to provide rent and utilities subsidy and continue as a state-funded service
    b. Develop a "new" H00043, per diem, as a Medicaid funded supported housing rate
    c. Develop a "new" H0044, per month, as a Medicaid funded supported housing rate
    d. If the State continues to have a state only rate for rent and utilities subsidy and new supportive housing rates as suggested in b and c, which CSH wholly supports, a new HCPCS or modifier would be needed for the state-only service in order to differentiate among payers.

Step 1: Additional Information about Supportive Housing Supportive Housing Providers

CSH has provided a list questions and answers by way of background to help understand the important role SH providers play in providing affordable housing in Arizona.

Q. What defines a supportive housing Provider

A. There is no certification process for supportive housing providers, unless they are also a licensed behavioral health or other type of service provider. The CoC is in the process of developing 'Supportive Housing Standards' that will be used to evaluate programs. A current roll-out strategy for the evaluation process is underway.

There are 3 distinct components of supportive housing: services, operations (property management, rent collection, maintenance, etc.), and capital (acquisition/rehab, reserves, etc.). Supportive housing combines affordable housing with services that help people who face the most complex challenges to live with stability, autonomy and dignity. Supportive housing is characterized by the following standards:

- Move people into housing directly from streets and shelters without preconditions of treatment acceptance or compliance.
- The provider is obligated to connect tenants with supportive services, which are predicated on assertive engagement, not coercion.
- Continued tenancy is not dependent on participation in services.
- Units are targeted to most disabled and vulnerable individuals and families.
- Services are individuals and designed to maximize tenant independence and self-sufficiency.
- Residents have leases and tenant protections under the law.
- Can be implemented as either a project-based or scattered site model.

Q. How many supportive housing providers are in Arizona?

A. 40 supportive housing providers funded through the Continuum of Care, U.S. Department of Housing and Urban Development (HUD).

Q. Do supportive housing providers hire clinical staff? What are their qualifications, job titles?

A. Supportive housing providers generally do not hire clinical staff, but partner (informally or contractually) with behavioral health providers with licensed staff. There are a few supportive housing providers that operate licensed behavioral health programs that provide clinical services through their behavioral health entity.

Q. Are supportive housing providers also ADHS licensed or Title XIX certified behavioral health providers? If so, what percentage?

A. Generally no. There are a few that do provide both SH and behavioral health services (Native American Connections, CPSA, and the Guidance Center).

Q. Do supportive housing providers contract with RBHAs?

A. RBHA contracts are generally limited to supportive housing providers that serve the SMI or other RBHA priority population(s). Supportive housing providers that serve the GMHSA population generally do not have access to RBHA contracts.

Q. What services do supportive housing providers provide?

A. Non-clinical outreach/engagement, assessment, case management, independent living skills, non-emergency transportation, supported employment, coordination of care activities, crisis support, self-help/peer support, behavioral health prevention/promotion and other services that facilitate entry to and retention of supportive housing.

Q. What is the primary funding source for supportive housing providers?

A. Services – HUD Continuum of Care, Private fund raising/philanthropy, RBHA's (SMI); Operating – HUD Continuum of Care, Public jurisdictions (State, County, City); Capital – HUD Continuum of Care, Low Income Housing Tax Credits (private equity investment), State Department of Housing, Local Jurisdictions (County, City), private loans.

Q. Approximately how many people are served by supportive housing providers, annually?

A. 7,350 (HUD CoC Homeless Assistance Programs Housing Inventory Count Report, 2014)

Q. How many people served by supportive housing providers are Medicaid eligible? Has AHCCCS for their insurance coverage?

A. The majority of people served by supportive housing providers are Medicaid eligible. In order to qualify for supportive housing through the Continuum of Care, households must be homeless or imminently at risk of homelessness and must meet low income qualifications as defined by HUD. Furthermore, HUD prioritizes 'chronically homeless' individuals for housing resources. 'Chronically homeless' is defined by HUD as having at least 4 instances of homelessness in the past 3 years or 1 year of continuous homelessness and having a disability. A recent survey of tenants at a Phoenix supportive housing property for chronically homeless individuals found 100% had AHCCCS coverage.

Q. Who benefits from supportive housing services?

A. While supportive housing is a useful intervention for a wide range of people who are homeless or at risk of homelessness, CSH focuses on working with our partners to create supportive housing opportunities for adults, youth/young adults, and families with children who:

- Have extremely low-incomes, defined as household income no higher than 30% of Area Median Income; and

- Have chronic health conditions that are at least episodically disabling, such as mental illness, HIV/AIDS, and/or substance use issues, and/or face other substantial barriers to housing stability (such as experiences of domestic violence or other trauma or have histories of out of home placements); and
- Are not able to obtain or retain appropriate stable housing without easy, facilitated access to services focused on providing necessary supports to the tenant household. These target populations include people who may be homeless (for any length of time) or are at risk of homelessness, and includes those who may be exiting other systems of care without a place to live, such as (1) young people aging out of foster care, (2) people with mental illness or other disabilities leaving jail or prison, and (3) some members of the elderly population.

Step 2: Provider Survey

CSH recommends that AHCCCS and ADHS/DBHS develop a provider survey to gather information from both supportive housing and behavioral health providers, as applicable. This survey could be accompanied by any financial reports specific to the services in question. There should be some boundaries around the types of information requested since supportive housing services can encompass so many different types of services. The State may first want to consider what types of services should be included in bundled per diem or monthly supported housing service.

As an example, the provider survey could include the following information (all based on a 1.0 FTE at 2080 hours of available work hours per year)[2]:

- Staff positions directly related to supportive housing services, including those with a support (not administrative) role
- Annual staffing hours by position allocated to supportive housing services by supportive housing service. For example:
    - Landlord/Tenancy relations
    - Skills training and development
    - Case management (or surrogate non-clinical service)
    - Behavioral health prevention/promotion
    - Non-emergency transportation
    - (This list would include only those services AHCCCS ADHS/DBHS would like to include in a new bundled rate, most likely non-licensed services)
- Annual staffing hours by position allocated to indirect supportive housing services. For example:
    - Direct contact with member (face to face or by telephone)
    - Collateral contacts made on behalf of a member
    - Record keeping
    - Agency required training and professional development
    - Supervision time
    - Vacation/sick time
- On-call costs, if applicable
- Vehicle costs with non-emergency transportation
- Vehicle costs associated with staff transportation
- Annual staffing salary by supportive housing position
- Number of client visits by a supportive housing staff member annually

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[2] The list does not include analysis of the indirect and administrative costs associated with the SH provider organizations. Those costs should be figured into the new rate in addition to those listed.

Step 3: Establish Value-Based Rates

This phase would include an analysis of the information gathered in the previous steps. Draft rates would be available for public review and feedback; including the assumptions used for direct and indirect services included in the rates. The State may want to consider if there would be any financial impact on the service delivery system and thus on the capitation rates paid to ADHS/DBHS and the RBHAs. The rates would be given to AHCCCS for review, approval and incorporation into the fee-for-service schedule.

If a bundled rate for supportive housing services is feasible, it should also be efficient. Are there savings if services are bundled versus services separately billed? Are there a max number of days a person can receive supportive housing services if paid as a per diem; or similarly, a max number of months?

IV. Other Considerations: Allowable Provider Types and Impact on Other AHCCCS and ADHS/DBHS Populations and Initiatives

Provider Types

AHCCCS and ADSH/DBHS have established the following allowable provider types for H0043: RBHA/RBHA (72), Out of State 1 Time Provider (73), Behavioral Health Outpatient Clinic (77), Integrated Clinic (IC), and Community Service Agency (A3).

The types of services included in the new supported housing bundled rate will determine what provider qualifications are needed and which provider types can deliver the supported housing service. In the CSH Fall 2014 paper, we also recommended allowing supportive housing providers to become Community Service Agencies for the purpose of delivering supportive housing services:

> *"3. Enable supportive housing providers to bill Medicaid for services as Community Services Agencies (CSA) as defined by the Arizona Department of Health Services, Division of Behavioral Health Services. CSAs provide services that enhance or supplement behavioral health services that persons receive through other, licensed agencies In order to adequately fund services."*

One of the services provided by supportive housing providers is case management. Case management is not currently an allowable service by a CSA. Other services such as skills training, psycho-educational services, psychosocial rehabilitation, and behavioral health prevention/promotion can be provided by CSAs and are services provided by supportive housing providers.

It is unclear to CSH whether or not the CSA provider type is a viable option as a provider of supportive housing services. Moving forward, CSH is pleased to work with AHCCCS and ADHS/DBHS to consider alternative provider types.

Other AHCCCS Populations

There may be other AHCCCS populations that use or need supportive housing services. AHCCCS would need to consider the fiscal and service delivery changes, if any, needed for other covered populations. For example, the dual-eligible GMH/SA populations will be covered by the Acute Health Plans effective 10/1/2015.