Utah Department of
Health & Human Services
Integrated Healthcare

Utah Medicaid Provider Manual

Housing Related Services and Supports

Division of Integrated Healthcare

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1 Overview

The Housing Related Services and Supports (HRSS) program provides tenancy support, community transition, and supportive living services to Medicaid members experiencing homelessness, food insecurity, transportation insecurity, interpersonal violence, and/or trauma. HRSS services are provided under the authority of the Utah Medicaid Reform 1115 Demonstration Waiver. Services are to be delivered in accordance with this manual and the special terms and conditions as set forth by the Centers for Medicare and Medicaid Services (CMS). (See also, https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ut-pcn-appvl-03042022.pdf)

2 Eligibility

HRSS services are available to Medicaid members, ages 19 through 64, who are members of the Targeted Adult Medicaid (TAM) and the Medicaid Adult Expansion (AE) population and meet the needs-based criteria and risk factors criteria.

The eligibility criteria are consistent with the TAM program and the Medicaid AE program combined with eligible clinical risk factors.

Note: TAM eligibility/criteria may have been determined by an entity other than the prospective HRSS provider.

3 Clinical risk factors

1. Complex behavioral health need: Requires improvement stabilization, or prevention of deterioration of functioning (including ability to live independently without support) resulting from the presence of a diagnosable substance use disorder, serious mental illness, developmental disability, cognitive impairment, or behavioral impairment resulting from dementia, brain injury or other medically-based behavior condition/disorder.
2. Needs assistance with one or more activities of daily living (ADLs), instrumental activities of daily living (IADLs), or eligible for long term

services and supports (LTSS). One of which may be body care, verbal queuing, or hands-on assistance.

3. Recent hospitalization for a chronic health condition (within the last 12 months, with at least one (1) inpatient claim for one of the following:

   Cancer, diabetes, hypertension, heart disease, heart failure, kidney disease, kidney transplant failure, liver disease, multiple sclerosis, necrotizing fasciitis, or renal failure.

   Utah Medicaid's Medical Director may approve additional chronic conditions on a case-by-case basis.

4. At-risk of or transition from emergency department/hospitalization or institutional care.
5. Must have an acute medical condition that can be safely managed in a recuperative care program setting, and medical respite care is necessary to provide the conditions to support recovery from the acute medical condition and meet one of the following: are at risk of emergency department (ED), hospitalization or institutional care as determined by a qualified healthcare professional, or are in the ED/hospitalized, or are in institutional care.

4 Authorization of services

All services must be documented in the initial care plan and approved by the Utah Department of Health and Human Services (DHHS) HRSS staff. Providers must submit care plan requests to LTSS_housing@utah.gov. A care plan template is located on the HRSS webpage at: https://medicaid.utah.gov/hrss. Please review the general guidance documents for each service in Chapter 5 of this manual. Chapter 5 provides additional information, requirements, and limitations for these services.

Once the services are approved by DHHS, they may be provided. If the service requires payment upfront, such as an application fee or household items etc., the provider will pay for the service/item and bill Medicaid for reimbursement.

If additional services are needed after the initial care plan approval, an updated care plan will need to be submitted with the required documentation explaining the need for the additional services to LTSS_housing@utah.gov.

5 Benefits

5-1 Tenancy support services

Tenancy support services assist the Medicaid member and includes the following:

1. Tenant screening and housing assessment to identify housing preferences (e.g., housing type, location, living alone or with someone else, roommate identification, type of accommodations needed, etc.), barriers to successful tenancy, identification of housing transition and retention barriers;
2. Development of an individualized housing support plan to address identified barriers and establish goals to address each issue, and identification of providers/services required to meet the established goals;
3. Development of a housing support crisis plan to identify prevention and early intervention services if housing is jeopardized;
4. Participation in planning meetings to assist members with the development of a housing support and crisis plan to address existing or recurring housing retention barriers;
5. Assistance with the housing application process, including application/documentation completion and submission;
6. Assistance with completing reasonable accommodation requests;
7. Assistance with the housing search process;
8. Identification of resources to cover housing expenses (e.g., rental application fees, security deposits, moving costs, furnishings, adaptive aids, environmental modifications, and other one-time expenses);
9. Ensure the living environment is safe and move-in ready;
10. Connect members to education and training on tenant and landlord rights and responsibilities;
11. Provide eviction risk reduction services (e.g., conflict resolution skills, coaching, role-playing, and communication strategies targeted towards resolving disputes with landlords and neighbors);

12. Communicate with landlords and neighbors to reduce the risk of eviction;
13. Address biopsychosocial behaviors that put housing at risk;
14. Provide ongoing support with activities related to household management; and
15. Assistance with the housing voucher/subsidy application and recertification processes.*

* Tenancy support services helps to identify the necessary items a member may require for successfully obtaining housing but should not be used for the purchase of the items or payment of application fees. Community transition services should be utilized for these items.

Members who are also receiving TCM services described above should utilize the Tenancy support services code/billing when working with the member on housing assistance.

5-1.1 Qualified tenancy support service providers

Qualified providers of tenancy support services to eligible members are certified and in good standing as a case manager by the Office of Substance Use and Mental Health or a licensed professional authorized to provide these services. Each case manager is also required to be enrolled in the Medicaid PRISM system as a licensed professional, a servicing only provider or an ordering/referring/prescribing (ORP) provider within 90 days. Providers who are not enrolled within the 90-day timeframe will not be reimbursed for HRSS services. If there are any delays in certification or enrollment, please notify the HRSS team.

5-1.2 Documentation of tenancy support services

The tenancy support service record must be maintained on file in accordance with any federal or state law or state administrative rules and must be made available for state or federal review, upon request.

The following documents must be contained in each member's case file:

1. A written, individualized housing needs assessment which documents the member's need for tenancy support services;
2. A written, individualized tenancy support services plan that identifies the services the member is to receive, who will provide them, and a general

description of the tenancy support services activities needed to help the member obtain or maintain these services;

3. A written review of the service plan that summarizes the member's progress toward service plan objectives;
    a) Written reviews of the service plan must be conducted every 180 days or more frequently.
    b) The service plan review must be completed within the month it is due, or more frequently as required by the member's condition.
    c) If changes are required in the written service plan, a revised service plan must also be developed.
    d) When constructing periodic review timelines, the provider should also be aware of the member's potential TAM review/termination date.
    e) The service plan is not a guarantee of payment. It is the provider's responsibility to verify a member's ongoing eligibility on a periodic basis.
4. Mutual expectations agreement; and
5. Tenant housing services contract.

The tenancy support service provider must develop and maintain sufficient written documentation for each unit of tenancy support services billed.

For each date of service, documentation must include:

1. Date, start and stop time and duration of each service;
2. Setting in which the service was rendered (when via telehealth, the provider setting and notation that the service was provided via telehealth);
3. At the end of the day, the total number of minutes of each tenancy support service based on the rules specified in the billing section below;
4. At a minimum, one note summarizing all of the tenancy support service activities performed during the day, or a separate note summarizing each tenancy support service activity. Notes must document how the activities relate to the tenancy support service plan and must be sufficient to support the number of units billed or reported; and
5. Signature and licensure or credentials of the individual who rendered the tenancy support service.

HCPCS Billing Code: T2024 – Tenancy support service - per 15 minutes

1. When billing these procedure codes, follow the rules specified below for converting the total duration of tenancy support services provided in a day to the specified unit.
2. The number of 15-minute units of service billed or reported cannot exceed 4 units in an hour and cannot exceed in total billings in a day the number of hours the tenancy support service provider worked (e.g., 8-hour workday).
3. If the total duration of tenancy support services activities provided in a day total less than 15 minutes, there must be a minimum of 8 minutes in order to bill one 15-minute unit.
4. If the total duration of tenancy support service activities provided in a day are in excess of 60 minutes, divide the total number of minutes by 15 to determine the number of 15-minute units that can be billed or reported. If there are minutes left over, apply the following rules:
    a) 1-7 minutes equal 0 units; and
    b) 8-15 minutes equals one 15-minute unit.
    c) For example, the tenancy support service provider performed five separate targeted case management activities for the client during the day for a total duration of 70 minutes. When divided by 15, this would result in 5 units of service.
5. A range of dates should not be billed on a single line of a claim (e.g., listing on the claim the 1st through the 30th or 31st as the service date). Each date of service should be billed on a separate line of the claim.

5-2 Community transition services

Community transition services are provided to assist eligible members moving from an institution, a congregate living arrangement, a more restrictive to a less restrictive community setting, members who are homeless, or those lacking safe and secure housing, to secure, establish, and maintain a safe and healthy living environment. Services include:

1. One-time purchase of essential household items and moving expenses required to occupy and use a community domicile, including:
    a) Furniture, window coverings, food preparation items, and bed/bath linens;
    b) Services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy;
    c) Moving expenses;
    d) Necessary home accessibility adaptations;
    e) Activities to assess, arrange and procure necessary resources;

f) Services needed to establish basic living arrangements in a community setting, including kitchen, bathroom, and cleaning equipment/goods.

2. One-time payment of a security deposit when a member moves into a new residence and a deposit is required for a member to obtain a lease. The state will impose a maximum of no more than two security deposit payments per member during the five-year demonstration approval period.
3. One-time non-refundable fees to submit rental applications, establish utility and other services (such as pest eradication) that are essential to the operation of the residence.

Services are provided when determined reasonable and necessary, when identified in a member's housing support plan, and when the member is unable to secure funding/items from other sources. Entities that coordinate the purchase of equipment or supplies or that pay deposits or other set-up fees for Medicaid members must be enrolled Medicaid providers that are:

1. Housing authorities;
2. Public or private not-for-profit service organizations;
3. Faith-based organizations;
4. State or local departments and agencies, units of local governments; or
5. Homeless services providers (who provide housing/homeless services to individuals and/or families who are experiencing homelessness or are at risk of becoming homeless).

HCPCS Billing Code: T2038 – 2 episodes per 5-year period per person up to $2,000 per each occurrence.

5-3 Supportive living services

Supportive living services are designed to assist members to retain established housing and coordinate needed services. An entity that provides supportive living services for Medicaid members must be Medicaid enrolled providers.

Coordinated services may include the following, excluding room and board costs:

1. Medical care coordinating medication reminders, health and wellness education, connection to nutritional counseling, home health aides, and personal care services;

2. Mental health services scheduling and coordination of screenings, assessments, counseling, psychiatric services, clubhouses, peer support services, and assertive community treatment teams;
3. Substance use disorder services access to providers of relapse prevention, counseling, intensive outpatient services, medication assisted treatment, detoxification, residential services, and formal/informal (Alcoholic Anonymous/Narcotics Anonymous) recovery support services;
4. Independent living services including financial management, entitlement assistance, cooking and meal preparation training, and mediation training; and
5. General supportive services including case management, community support, peer support services, crisis intervention, and non-medical transportation.

5-3.1 Qualified supportive living service providers

Qualified providers of supportive living services to eligible members are certified and in good standing as a case manager by the Office of Substance Use and Mental Health or a licensed professional authorized to provide these services. Each case manager is also required to be enrolled in the Medicaid PRISM system as a licensed professional, a servicing only provider or an ordering/referring/prescribing (ORP) provider within 90 days. Providers who are not enrolled within the 90-day timeframe will not be reimbursed for HRSS services. If there are any delays in certification or enrollment, please notify the HRSS team.

5-3.2 Documentation of support living services

The supportive living service record must be maintained on file in accordance with any federal or state law or state administrative rules and must be made available for state or federal review, upon request.

The following documents must be contained in each member's case file:

1. A housing assessment which documents the member's need for supportive living services;
2. A written, individualized supportive living services plan that identifies the services the member is to receive, who will provide them, and a general description of the supportive living services activities needed to help the member obtain or maintain these services; and

3. A written review of the service plan, at a minimum every 180 days, which summarizes the member's progress toward service plan objectives. The service plan review must be completed within the month it is due, or more frequently as required by the member's condition. If changes are required in the written service plan, a revised service plan must also be developed.

The supportive living service provider must develop and maintain sufficient written documentation for each unit of supportive living services billed.
For each date of service, documentation must include:

1. Date, start and stop time and duration of each service;
2. Setting in which the service was rendered (when via telehealth, the provider setting and notation that the service was provided via telehealth);
3. At the end of the day, the total number of minutes of each tenancy support service services based on the rules specified in the billing section below;
4. At a minimum, one note summarizing all of the tenancy support service activities performed during the day, or a separate note summarizing each tenancy support service activity. Notes must document how the activities relate to the tenancy support service plan and must be sufficient to support the number of units billed or reported; and
5. Signature and licensure or credentials of the individual who rendered the tenancy support service.

HCPCS Billing Code: T2017 – Supportive living service - per 15 minutes

1. When billing these procedure codes, follow the rules specified below for converting the total duration of supportive living services provided in a day to the specified unit.
2. The number of 15-minute units of service billed or reported cannot exceed 4 units in an hour and cannot exceed in total billings in a day the number of hours the supportive living service provider worked (e.g., 8-hour workday). Only time worked with the participant may be claimed for reimbursement.
3. If the total duration of supportive living services activities provided in a day total less than 15 minutes, there must be a minimum of 8 minutes in order to bill one 15-minute unit.

4. If the total duration of supportive living service activities provided in a day are in excess of 60 minutes, divide the total number of minutes by 15 to determine the number of 15-minute units that can be billed or reported. If there are minutes left over, apply the following rules:
    a) 1-7 minutes equal 0 units; and
    b) 8-15 minutes equals one 15-minute unit.
    c) For example, the supportive living service provider performed five separate targeted case management activities for the client during the day for a total duration of 70 minutes. When divided by 15 this would result in 5 units of service.
5. A range of dates should not be billed on a single line of a claim (e.g., listing on the claim the 1st through the 30th or 31st as the service date). Each date of service should be billed on a separate line of the claim.