NEW MEXICO | 2017

MEDICAID SUPPORTIVE HOUSING SERVICES

crosswalk

About CSH

CSH transforms how communities use housing solutions to improve the lives of the most vulnerable people. We offer capital, expertise, information and innovation that allow our partners to use supportive housing to achieve stability, strength and success for the people in most need. CSH blends over 25 years of experience and dedication with a practical and entrepreneurial spirit, making us the source for housing solutions. CSH is an industry leader with national influence and deep connections in a growing number of local communities. We are headquartered in New York City with staff stationed around the country. Visit csh.org to learn how CSH has and can make a difference where you live.

Acknowledgments

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In 2009, the Social Innovation Fund was created as part of the Corporation for National & Community Service to find solutions that work, and make them work for more people – by proving, improving and scaling effective models. SIF and its non-federal partners have invested nearly $1 billion in effective community solutions since the program's inception. Launched in 2014, the SIF Pay for Success (PFS) program is designed to help cities, states, and nonprofits develop Pay for Success projects where governments pay service providers only when there are demonstrable results.

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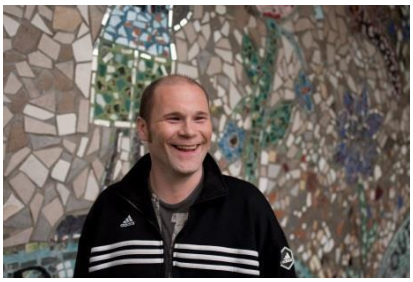
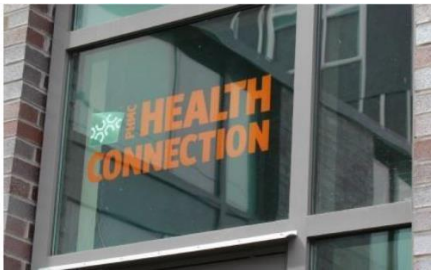
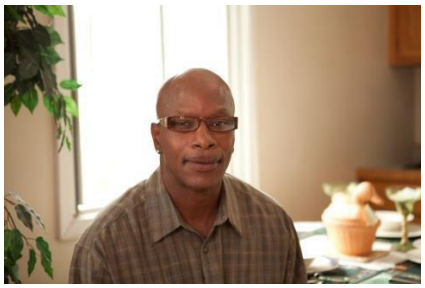
Note: Pay for Success (PFS) is a general term for performance-based contracting between government and social service providers, where government only pays providers if target outcomes are achieved, e.g. reduced recidivism or improved health outcomes, as opposed to providing cost reimbursement payments.

We would also like to acknowledge the valuable partnership of the Government Performance Lab at the Harvard Kennedy School (GPL) in conducting the Crosswalk Analysis and drafting this report.







INTRODUCTION

In partnership with New Mexico's Behavioral Health Services Division (BHSD) and Medical Assistance Division (MAD), CSH and GPL conducted a Medicaid Supportive Housing Services Crosswalk (hereinafter, the Medicaid Crosswalk). The Medicaid Crosswalk is part of the feasibility technical assistance that New Mexico's Human Services Department is participating in focused on evaluating the potential of the PFS model as a tool to scale supportive housing for vulnerable populations in New Mexico. PFS pairs performance-based contracting with an innovative financing mechanism in which private investors provide the upfront capital needed to implement a proven intervention such as supportive housing and are repaid if success is achieved. Part of the PFS feasibility process is focused on understanding the current landscape as it relates to the resources currently available to implement supportive housing. As detailed in this report, the Medicaid Crosswalk helps to illustrate the extent to which New Mexico's Medicaid program aligns with supportive housing services. This helps to narrow in on the opportunity to use PFS to scale supportive housing and drive toward a sustainable model for housing and services for vulnerable populations in New Mexico. To learn more about PFS, visit www.csh.org/pfs and http://govlab.hks.harvard.edu/.

As noted, the Medicaid Supportive Housing Services Crosswalk examines the extent to which New Mexico's Medicaid program aligns with supportive housing services for adults with significant housing and service needs. Supportive housing services include pre-tenancy supports and housing transition services, tenancy-sustaining services, and wrap-around care management support services.

This report consists of four parts:

- Part One – Background and definitions for supportive housing and Medicaid.
- Part Two – Brief overview of key aspects of the State's Medicaid program and reimbursable supportive housing services.
- Part Three – Key areas of alignment and gaps identified through the Crosswalk together with interview results from local supportive housing provider agencies
- Part Four – CSH's recommendations for the steps New Mexico can take to maximize Medicaid to pay for supportive housing services.

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I. Background and Definitions

Within New Mexico, state leaders, social service workers, and health care providers have identified a critical group of residents who have serious unmet housing and healthcare needs. These residents make up a small percent of the population, yet their unmet needs present significant system costs to the State. Many of these highly vulnerable individuals are living with multiple chronic health conditions as well as complex behavioral health challenges, including severe mental illness and substance use disorders. Most have extremely low incomes and many are unstably housed, homeless and/or cycling through multiple social service systems and institutions. Despite their frequent use of public systems such as long-term care facilities, jails, shelters, and hospitals, these individuals are not receiving the care they need, and therefore are not experiencing improved health outcomes. Instead, they experience expensive and often preventable institutionalization, a lack of access to primary care and a lack of integrated services addressing their co-occurring disorders and co-morbidities. While these residents represent a small percent of the total state population, their healthcare costs constitute a large and disproportionate percent of New Mexico's expenditures.

A. Supportive Housing

Supportive housing combines affordable housing with intensive tenancy support services to help people who face the most complex challenges to live with stability, autonomy, and dignity. Research demonstrates that supportive housing provides housing stability, improves health outcomes, and reduces public system costs. Supportive housing is not affordable housing with resident services. It is a specific intervention that uses a tenant-centered, flexible approach to eliminate barriers to housing, employing principles of harm reduction and consumer choice in all service delivery, and providing specialized housing-based tenant support services with low client-to-staff ratios (generally one-to-fifteen and not more than one-to-twenty-five).

THE WORLD HEALTH ORGANIZATION IDENTIFIES HOUSING AS A KEY COMPONENT OF HEALTH, WHICH MEANS THAT HOUSING IS AN UNDERLYING AND MEANINGFUL CONTRIBUTOR TO HEALTH OUTCOMES.

Quality supportive housing projects are as diverse as the communities in which they are located. Despite these differences, all supportive housing:

- Targets households whose heads of household are experiencing homelessness, are at risk of homelessness, or are inappropriately staying in an institution. They may be facing multiple barriers to employment and housing stability, including mental illness, substance use, and/or other disabling or chronic health conditions;
- Is affordable, meaning the tenant household ideally pays no more than 30% of its income toward rent;
- Provides tenant households with a lease or sublease identical to non-supportive housing — with no limits on length of tenancy, as long as lease terms and conditions are met;
- Proactively engages members of the tenant household in a flexible and comprehensive array of supportive services, without requiring participation in services as a condition of ongoing tenancy;
- Effectively coordinates with key partners to address issues resulting from substance use, mental health and other crises, with a focus on fostering housing stability; and
- Supports tenants in connecting with community-based resources and activities, interacting with diverse individuals including those without disabilities, and building strong social support networks.

The core services in supportive housing are pre-tenancy (outreach, engagement, housing search, application assistance, and move-in assistance) and tenancy-sustaining services (landlord relationship management, tenancy rights and responsibilities, education, eviction prevention, crisis intervention, and subsidy program adherence) that help people access and remain in housing. In addition, supportive housing service providers link tenants to clinical primary and behavioral health care services. Finally, services such as counseling, peer supports, independent living skills, employment training, end-of-life planning and crisis support are also routinely provided for supportive housing residents.

The homelessness response system fully embraces supportive housing as a best practice for ending chronic homelessness, but it does not have the resources to take this intervention to scale. A lack of sustainable services funding often delays the creation of new supportive housing units. Supportive housing service providers who either do not bill Medicaid or are not maximizing their Medicaid billing use a significant amount of resources that could pay for housing or non-Medicaid eligible services to stretch dollars further and create more supportive housing. Proper Medicaid reimbursement for services can allow providers to reallocate their more flexible resources to housing related activities (rental assistance and capital costs) and create more supportive housing units.

B. Medicaid

Medicaid is public health insurance that pays for essential medical and medically-related services for people with low-incomes. Statutorily, Medicaid insurance cannot pay for room and board directly. Medicaid's ability to reimburse for services starts with a determination as to whether the services are medically necessary.

C. Medicaid State Plan

States and the federal government jointly finance the Medicaid program. The Centers for Medicare and Medicaid Services (CMS) oversee all state Medicaid plans. A Medicaid "State Plan" is the contract between that state and the federal government that determines which services are covered and how much each entity will pay for the program. All state plans cover certain mandatory benefits as determined by federal statute. States and CMS can also agree to cover additional benefits designated as 'optional' in federal statute.[1] For example, Medicaid's rehabilitative services option is an optional benefit that states use to cover a fairly broad range of recovery-oriented mental health and substance use disorder services. For CMS to approve optional benefits, states must meet CMS rules. For the rehabilitation[2] option, the service must meet the purposes of "reducing disability and restoring function.[3] "

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[1] For more detail on mandatory and optional Medicaid benefits - Information/By-Topics/Benefits/Medicaid-Benefits.html

[2] Medicaid distinguishes between rehabilitative services and habilitative services. Rehabilitative services are aimed at restoring a previous level of functioning that was lost. Habilitative services are designed to assist individuals in *acquiring*, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings. Habilitative services can be covered by Medicaid through a HCBS waiver or optional HCBS State Plan services. Habilitation is one of the Essential Health Benefits that must be offered when a state adopts an "Alternative Benefit Plan" to provide coverage to people who are newly eligible for Medicaid beginning in 2014. States have some flexibility to determine how to design and implement these benefits and plans, consistent with rules established by the Federal Government. On July 15, 2013, HHS and CMS issued a Final Rule that includes several changes in the Medicaid program, including requirements to ensure that Medicaid benefit packages include Essential Health Benefits and meet certain other minimum standards. This Final Rule can be found at https://www.federalregister.gov/articles/2013/07/15/2013-16271/medicaid-and-childrens-health-insurance-programs- essential-health-benefits-in-alternative-benefit#h-14.

[3] Wilkins, C., Burt, M., and Locke, G. (July 2014). A Primer on Using Medicaid for People Experiencing Chronic Homelessness and *Tenants in Permanent Supportive Housing*. Page 32. Available at: http://aspe.hhs.gov/daltcp/reports/2014/PSHPrimer.cfm.

D. Medicaid Waivers and Amendments

States can apply to CMS to amend their current state plan to include new or revised services for the entire state population. The approved revisions to the state plan are called state plan amendments (SPA) and are considered a Medicaid authority after approval by CMS. Changes to health care delivery, services or payments that waive certain federal requirements (like eligibility requirements or geographical requirements) are known as waivers. Waivers are commonly used by states to offer unique care to specific populations for Home and Community Based Services (HCBS). Waivers are also used to pilot innovative demonstration projects such as for a specific population or for a specific geographic location (a managed care organization that will serve only one region of the state). Waivers and amendments are both referred to as Medicaid authorities, because they have been approved by the federal government, and have the authority to change or expand the existing contract the state has with the federal government.

Medicaid authorities are known by their federal statute section number and some of these authorities have particular applicability to supportive housing services. 1115 Medicaid waivers allow for state demonstration programs for new services, populations or payment structures (such as individuals who are chronically homeless or who have a substance use disorder). 1915(c) Waivers and 1915(i) state plan amendments help states target HCBS for specific populations (seniors, individuals with severe or persistent mental illness, developmental disabilities, children with special health care needs, people living with traumatic brain injuries). These services are designed to serve people in their own homes and communities rather than in institutions.

E. Medicaid reimbursement

Reimbursement for Medicaid services can be delivered in a variety of ways. States can reimburse providers directly for services or contract with managed care organizations (MCOs) to negotiate services and payment structures with providers. In some cases, MCOs also deliver services directly. States and MCOs establish agency licensing and credentialing requirements and staff qualifications that determine which providers can receive Medicaid reimbursement. Many MCOs aim to reimburse providers within 30 days of the provider submitting a claim.

II. NEW MEXICO'S STATE MEDICAID PLAN

In 2014, New Mexico expanded its Medicaid coverage to include most low-income adults who earn up to 138% of the federal poverty level. The impact of Medicaid expansion was predicted to be particularly significant for single adults living in poverty, as it was estimated that 36% of the 422,000 previously uninsured non-elderly New Mexicans were adults who are now eligible for Medicaid.[4] For individuals experiencing homelessness or unstably housed, the reality of Medicaid expansion has created an opportunity to receive coverage for health care services that previously may not have been accessible. These newly covered adults now have access to state plan services they didn't have before. It is critical that supportive housing services providers understand what services their clients are eligible to receive and what reimbursement providers might seek as they work to better integrate care, treat the whole person, and provide the right level of care at the right time in the right place.

This report examines New Mexico's Medicaid State Plan and how the medically necessary services included in the State Plan align with services received by residents of supportive housing. This report also includes an analysis of the Mi Via Waiver and the 1115 Centennial Care Demonstration Waiver which outlines how waiver benefits for highly vulnerable individuals living with intellectual or developmental disabilities and/or are medically fragile might align with supportive housing services that are provided to these same individuals living in the community.

A. Managed Care in New Mexico

New Mexico's managed care portion of the Medicaid Program, Centennial Care, provides physical health, behavioral health, and long-term care and community benefits through four managed care organizations to 680,000 New Mexicans. Most Medicaid-eligible New Mexicans participate in Centennial Care. As of 2014, MCOs included BlueCross Blue Shield of New Mexico, Molina Health Care, Presbyterian Health Plan, and United Healthcare Community Plan of New Mexico. MCOs contract with health care providers across the state to provide direct care to individuals enrolled in Centennial Care. These contracts may be fee-for-service (FFS) payment contracts or payments that are based on the number of individuals served by a provider, known as per member per day/month, payments.

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[4] Kaiser Family Foundation. "How Will the Uninsured in New Mexico Fare Under the Affordable Care Act?" http://kff.org/health-reform/fact-sheet/state-profiles-uninsured-under-aca-new-mexico/

B. Fee for Service Reimbursement in New Mexico

In New Mexico, some health services are reimbursable through its Fee-For-Service system. For example, FFS reimbursements are paid to FFS providers for individuals who are not enrolled in Centennial Care but who have Medicaid coverage, including Native American individuals who have not selected a Centennial Care plan and have opted to remain in the FFS System.

C. Reimbursement through Waiver Programs

New Mexico's Mi Via Home and Community Based Services Waiver is an example of a 1915(c) Waiver that promotes community integration and home-based care for individuals with intellectual and developmental disabilities. Other waivers, like New Mexico's 1115 Centennial Care Demonstration Waiver, serve medically frail individuals and people living with disabilities through MCOs coordinating HCBS. The New Mexico Supportive Housing Services Crosswalk includes a study of the services provided under these two waiver programs in order to determine how waiver program services might align with supportive housing services for eligible individuals (medically frail and people living with disabilities) in need of supportive housing.

III. Supportive Housing Services Crosswalk Findings

To determine the degree to which Medicaid currently pays for supportive housing services, CSH 'cross walked' the services provided in supportive housing with key provisions of the State Plan and the perceptions of providers who deliver supportive housing services. Sections A and B of the Crosswalk detail our analysis of alignment between the Plan itself and the services in supportive housing. Section C describes the degree to which supportive housing services are being provided by supportive housing providers throughout the State, as well as providers' perception of Medicaid benefits' alignment with supportive housing services.

A. State Plan Alignment

1. Supportive housing services aligned in Centennial Care

New Mexico's Medicaid, also known as Centennial Care, covers medically necessary services including:

- Routine medical care;
- Outpatient treatment/counseling for individuals with a mental health diagnosis, including individual, group and family therapy;

- Medication management and monitoring (including education about psychotropic medication);
- Methadone maintenance; and
- Treatment for substance use disorders.

Comprehensive Community Support Services

Many other supportive housing services align with benefits covered by Medicaid in New Mexico, when services are provided by specific types of provider agencies for eligible individuals. Comprehensive Community Support Services (CCSS) are an example of a covered Medicaid service that aligns with many services offered to supportive housing residents. CCSS can be provided to adults over the age of 18 with serious mental illness (SMI) or children/adolescents ages 0-18 with serious emotional disturbance (SED). CCSS for adults may not be provided in conjunction with Assertive Community Treatment (ACT). For the purpose of this report, the CCSS analysis will focus on services offered to adults.

CCSS are coordinated, culturally sensitive services that are necessary to promote independent living through recovery, rehabilitation, and resiliency. Provider agencies that are currently able to provide CCSS services include: Community Mental Health Centers (CMHCs); Federally Qualified Health Centers (FQHCs); and Core Service Agencies (CSAs). At least 60% of CCSS visits must be face to face and in vivo (i.e. in the client's home or community environment rather than in an office setting). Individualized service plans are created with clients receiving services through CCSS. Individualized service planning, which may include a client Wellness Recovery Action Plan (WRAP) can also include assessment of housing preferences and barriers related to tenancy and relapse prevention and recovery planning. Service planning is done with the client and incorporates the client's own treatment and recovery goals, which can include housing stability and successful tenancy.

CCSS Services that align with supportive housing services include:

- Assistance collecting required documentation for housing;
- Assistance with housing search and housing applications when the client is present;
- Education and training on tenant and landlord rights and responsibilities;
- Coaching on developing and maintaining relationships with landlords/property managers/neighbors;
- Advocacy and linkage with community resources to prevent eviction and sustain successful tenancy; and

- Care coordination and services referral (as a part of case management).

Health Home Services

Health Homes can bill Medicaid for health and wellness education. This could include training in meal cooking and preparation, training in personal hygiene and self-care, training in housekeeping, and assistance with the activities of daily living. These services align with supportive housing services providing ongoing training and support activities related to household management and healthy tenant habits.

Home Health Aide Services

Table 1 below highlights home health aide services that also align with supportive housing services. Home health aide services are covered by Medicaid with prior approval when determined medically necessary, including a determination that the individual is physically unable or has great difficulty leaving the home to obtain necessary medical care and treatment or that the medical need for care at home is more appropriate and cost-effective and will prevent or delay institutionalization. Home health aide services must be delivered under the supervision of a registered nurse or other appropriate professional staff member.

Additional Services

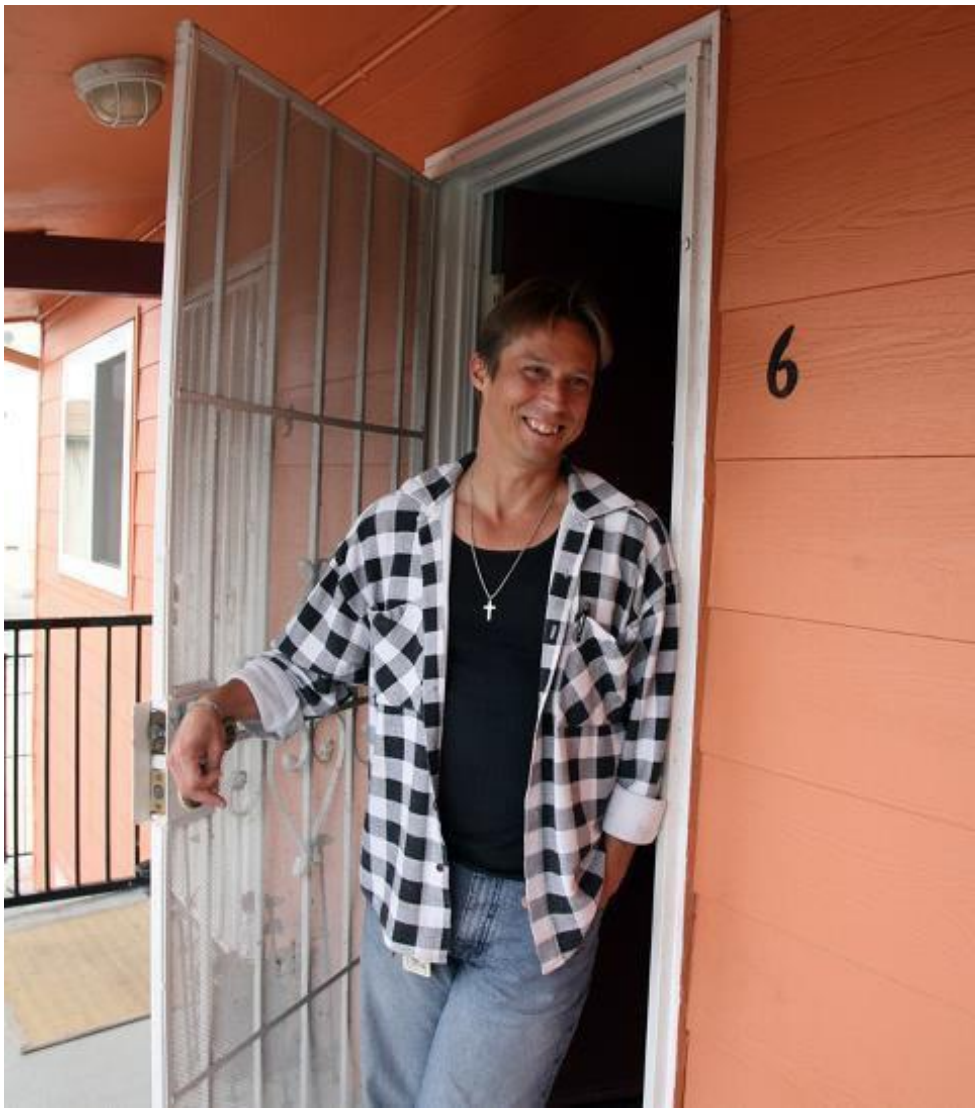
Some services, like those included in CCSS, are offered by multiple provider types. Case management is billable under CCSS, and therefore can be provided by CMHCs, FQHCs, and CSAs. It can additionally be billed by Certified Community Behavioral Health Clinics (CCBHCs) and health homes. Entitlement assistance and benefits counseling may be provided under CCSS and also through Health Homes. Additionally, health home providers and all other provider types who offer CCSS services can include services that align with some job readiness training like how to succeed at an interview.

Medicaid benefit services that align with supportive housing services are outlined in Table 1 below. Supportive housing services that align with Medicaid benefit services are noted with a "√" mark and categorized according to provider type.

Table 1: Supportive housing services currently aligning with services that are covered by NM Medical Assistance

	BHA	CCBHC	CMHC (not providing CCSS)	CSA (or any CCSS provider including CMHC & FQHC)	FQHC (without CCSS)	Health Homes	IHS	PL93-638
	√	√	√	√	√	√	√	√
			√	√	√		√	√
Case management		√		√	√	√		
Entitlement assistance/benefits counseling				√		√		
Assistance with housing search and housing applications and collecting required documentation				√				
Developing housing support crisis plans			√	√				
Education & training on tenant/landlord rights and responsibilities, coaching on relationships with landlords, property managers, neighbors				√				
Advocacy & connection to resources to prevent eviction, maintain tenancy				√				
Relapse prevention and recovery planning				√				
Preventive health: training in household management and healthy tenant habits and health and wellness education						√		
Limited job readiness training				√		√		
Review and modify housing support plan, if part of a treatment plan		√		√	√	√		
Assessment of housing preferences and barriers to tenancy		√		√	√	√		
Peer mentoring (Certified Peer Support Workers)	√	√	√	√	√	√	√	√
Family Support Services				√				

[5] Note that therapy can include individual, group and family therapy, peer mentoring and support, and domestic violence counseling if the client has a diagnosis. Additionally, several supportive services related to housing can be included in psychiatric outpatient treatment, as identified below in section 2, "Supportive Housing Services with Potential for Alignment."



2. Supportive housing services with potential for alignment

In New Mexico, many of these CMS-defined pre-tenancy and tenancy support services have the potential for alignment under a covered behavioral health service. Some can align when delivered as part of psychiatric outpatient treatment therapy sessions, while others might be delivered in the context of CCSS services through a WRAP plan. In order for supportive housing services to align with psychiatric outpatient treatment services, supportive housing services must be linked to a therapeutic need of the client, and may need to be documented in a client's treatment plan. Table 1 below outlines the supportive housing service and the corresponding behavioral health service with which it potentially aligns.

Table 2: Supportive housing services that have potential for alignment with Medicaid-covered services

Supportive Housing Service	Potential Alignment under Similar Behavioral Health Service
Communication skills	Psychiatric outpatient treatment (therapy)
Conflict resolution/mediation training	
Individual counseling/crisis support	
Motivational interviewing	
Relapse prevention and recovery planning	
Early identification/intervention for behaviors that could jeopardize housing	
Education/training on tenant and landlord rights and responsibilities (if tied to therapeutic need and therefore medical necessity)	
Coaching on developing and maintaining relationships with landlord/property manager/neighbors (if relationships with other people is a therapeutic goal)	
Assistance resolving disputes with landlords, property management, and neighbors (if relationships with other people is a therapeutic goal)	
Education about mental illness	
Coordination to review/modify/update a housing support plan if a housing support plan is part of the treatment plan	
Psychosocial services when provided in accordance with a written treatment plan	
Early identification/intervention for behaviors that could jeopardize housing	CCSS assessment and service plan
Assessment of housing preferences and barriers related to tenancy	
Housing Service Plan	
Assistance with collecting required documentation (i.e. birth certificate, IDs, credit history)	
Assistance with housing search and housing applications (client must be present)	
Development of housing support crisis plan	
Education/training on tenant and landlord rights and responsibilities (if tied to therapeutic need and therefore medical necessity)	
Coaching on developing and maintaining relationships with landlord/property manager/neighbors (if relationships with other people is part of treatment plan)	
Assistance resolving disputes with landlords, property management, and neighbors (if relationships with other people is part of treatment plan)	
Advocacy/linkage with community resources to prevent eviction/sustain successful tenancy	
Relapse prevention and recovery planning	
Job readiness training - resume writing, interviewing	
Assistance with accessing entitlements	

3. Other Related Behavioral Health Services

The New Mexico Medicaid plan also includes several specialty services that can be used to support clients in supportive housing.

Assertive Community Treatment

Clients of supportive housing may be served in New Mexico by an Assertive Community Treatment (ACT) team to provide many of the services identified above. ACT is a voluntary, intensive case management and psychosocial intervention program covered by Medicaid for individuals ages 18+. ACT is provided by BHAs, CMHCs, and CSAs, all with a letter from HSD/MAD approving the provider agency as an ACT provider after an on-site audit. ACT must be provided with fidelity to the model (including having a psychiatrist on the team) and with at least 90% of services being provided in the community. Services must be available 24 hours a day, seven days a week. The services are provided by an interdisciplinary team, which may include trained personnel such as psychiatrists, nurses, nurse practitioners, case managers, masters level behavioral health professionals, qualified peer providers, and clerical support staff. Collateral encounter and assertive outreach together cannot comprise more than 40% of total activities. No other psychiatric residential or therapeutic services, substance abuse, or crisis services can be billed while the person is on ACT unless those services are medically necessary. Individualized treatment plans and supports are developed for clients, and services are recovery-oriented.

ACT should operate with a low client-to-staff ratio. Mobilized crisis intervention is provided in various environments such as homes, schools, jails, homeless shelters, streets, and other locations. Supportive housing services identified in this document that align with ACT services include:

- Medically necessary services like psychiatric outpatient treatment**,** routine medical care, and medication management;
- Substance abuse outpatient treatment;
- Case management;
- Entitlement assistance/benefits counseling;
- Assistance with housing search and housing applications and collecting required documentation;
- Developing housing support crisis plans;
- Education/training on tenant/landlord rights and responsibilities;
- Coaching on developing and maintaining relationships with landlords/property managers/neighbors, with or without the client present;

- Advocacy and connection to resources to prevent eviction/maintain tenancy, with and without the client present;
- Relapse prevention and recovery planning;
- Preventive health: training in household management and healthy tenant habits and health and wellness education;
- Job skills training, job retention services, job development and placement services;
- Review/update/modify a housing support plan if a housing support plan is part of a treatment plan;
- Assessment of housing preferences and barriers to tenancy;
- Peer mentoring;
- Family Support Services;
- Communication skills, including support and skills for client's support network of family, landlords, and employers with or without the client present;
- Conflict resolution/mediation training;
- Individual counseling/crisis support;
- Motivational interviewing;
- Early identification/intervention for behaviors that could jeopardize housing;
- Assistance resolving disputes with landlords, property management, and neighbors (if relationships with other people is a therapeutic goal);
- Education about mental illness;
- Assistance with collecting required documentation (i.e. birth certificate, IDs, credit history);
- Assistance with accessing entitlements;
- Substance use case management;
- Discharge planning;
- Nursing/visiting nurse care;
- Assistance with housing recertification;
- Family advocacy and reunification;
- Ensuring housing unit is safe and ready for move-in and assistance with move-in arrangements; and
- Support groups including AA/NA/CA.

Crisis Intervention

Clients of supportive housing may find themselves in mental health crises. As identified above, crisis support may be aligned with psychiatric outpatient treatment and can be provided by an ACT team. However, if crisis intervention services are required in the community for a non-ACT client, Medicaid covers community-based mobile, telephonic, and site-based psychiatric crisis intervention. These billable crisis intervention services can be provided at a clinic or through a

mobile team and available 24/7, and must be immediate, cross-oriented services designed to ameliorate or minimize an acute crisis episode and/or to prevent inpatient psychiatric hospitalization or medical detoxification. Crisis Intervention services include crisis prevention, primary assessment, secondary evaluation, acute crisis services, and support services. For children, BHAs, CMHCs, and CSAs approved by CYFD may provide Crisis Intervention. For adults, CMHCs licensed by the New Mexico Department of Health (NMDOH) may provide Crisis Intervention. Practitioners delivering Crisis Intervention must be licensed Behavioral Health practitioners. Crisis Intervention cannot be billed in conjunction with ACT, MST, or Psychosocial Rehabilitation Program (PSR), or for Medicaid recipients in inpatient or residential settings. Crisis Intervention services are delivered in 15 minute increments with a maximum of 4 units each of services delivered by phone, in vivo, and mobile per day.

Intensive Outpatient Program

Many clients of supportive housing have substance use disorders. Intensive Outpatient treatment is time-limited, multi-faceted services for recipients who require structure and support to achieve and sustain recovery from alcohol and/or drugs. Intensive Outpatient services can be provided to: (1) adolescents ages 13-17 who are diagnosed with a substance use disorder, co-occurring disorders, or who meet ASAM patient placement criteria for level 2 (intensive outpatient treatment); and (2) adults ages 18 and over at BHAs, CMHCs, CSAs, FQHCs, IHS facilities, and PL 93-638 tribal facilities all with a letter from HSD/MAD approving the facility as an IOP Medicaid provider with ratification through an on-site audit by (1) CYFD for adolescents and (2) BHSD for adults. Services may be provided by non-independently licensed practitioners when supervised by an independently licensed behavioral health practitioner. A psychiatric evaluation is required in the 12 months prior to services.

Medication Assisted Treatment for Opioid Addiction

In New Mexico, opioid overdose deaths have been on the rise. Clients of supportive housing who are addicted to opioids may require medication assisted treatment for their addiction.

Methadone and buprenorphine (Suboxone) treatments in conjunction with counseling, therapy, case review and medication monitoring are covered for Medicaid recipients who have been addicted for over 12 months or who have a waiver with documented medical necessity. Services can be provided at Methadone Clinics that are opioid treatment centers as defined in 42 CFR, which requires DEA certification to operate an opioid treatment program (OTP), SAMHSA approval to

operate an OTP, Joint Commission (TJC) or CARF accreditation, and an approval letter from BHSD.

Psychosocial Rehabilitation Program

The Psychosocial Rehabilitation Program (PSR) covers a transitional level of care based on an individual's recovery and resiliency goals. The Program includes crisis services; psychosocial intervention, including basic living skills, psychosocial skills training and therapeutic socialization, therapeutic intervention, assessment, and initial treatment plan; specialized consultation; periodic treatment plan reviews; and medication management and monitoring. PSR is available to Medicaid recipients with SMI who are age 21 and over and who are not residents in institutions for mental illness, as well as youth ages 18 to 20 with SED if they met the criteria for SED prior to age 18. PSR can be provided by CMHCs and CSAs.

B. State Plan Gaps

Some supportive housing services do not align with the current New Mexico State Plan. These *gaps* in service are highlighted below and are also addressed in the Recommendations section at the end of this report.

1. Gaps in Populations Served (diagnoses, region)

There are a few populations who do not have a diagnosis of SMI or SED, but would benefit from coverage similar to that provided to individuals diagnosed with SMI or SED:

- Case management for individuals with Traumatic Brain Injury (TBI) living in the following counties: Bernalillo, Catron, Cibola, Colfax, Curry, De Baca, Eddy, Grant, Guadalupe, Harding, Hidalgo, Lea, Lincoln, Los Alamos, Luna, Mora, Otero, Quay, Rio Arriba, Roosevelt, Sandoval, Sierra, Socorro, Taos, Torrance, Union, and Valencia.
- Case management and support services for individuals with substance use disorders but who do not have a diagnosed SMI or SED.
- Case management and supportive services for individuals with multiple chronic health conditions who are homeless or unstably housed that are frequent users of emergency systems but who do not have a diagnosed SMI or SED.

2. Gaps in State Plan Language

The services identified below are services that are a part of the package of evidence-based practices for supporting individuals to live successfully in supportive housing

(including as outlined in the June 2015 CMCS Informational Bulletin "Coverage of Housing-Related Activities and Services for Individuals with Disabilities"[6]), yet are not explicitly included as covered services in New Mexico's Medicaid state plan, creating gaps in coverage for supportive housing services:

- Transportation, including training in use of public transportation;
- Ensuring housing unit is safe and ready for move-in and assistance with move-in arrangements (other than through ACT teams);
- Assistance with housing recertification;
- Discharge planning (other than through ACT teams);
- Liaison with psychiatrist;
- Substance use case management (other than through ACT teams); and
- Child care/day care/after school care, including in the event of parent illness/hospitalization.

C. Provider Interviews on Medicaid Coverage and Supportive Housing Services

The following section builds upon the analysis of covered supportive housing services and gaps in coverage in the Plan itself and presents identified gaps in practice. CSH conducted interviews with 6 supportive housing providers across New Mexico to learn the breadth and depth of services that providers are currently offering to tenants, regardless of the funding source. CSH also surveyed these same providers about their understanding of Medicaid reimbursement of supportive housing services. The information gained during the provider interviews is valuable because it highlights the inconsistencies between Medicaid reimbursable services and provider perceptions of Medicaid reimbursable services. Below is a summary of the interview findings and an analysis of the variation in responses across providers. Finally, each perception about covered services is then reconciled with the actual covered services outlined in the State Plan.

1. Supportive Housing Services Currently Offered by New Mexico Providers

During each provider interview, supportive housing providers are presented with a list of supportive housing services and supportive housing wrap around services that are commonly offered around the nation. Providers were then asked to identify which services they currently provide to tenants or future tenants of supportive housing, regardless of funding source. The results of these interviews concluded that most providers (50% or more of the providers interviewed) are offering the

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[6] https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-06-26-2015.pdf

following services categories. Within these services categories, almost all providers conduct a number of more specific services sub-listed below.

- Assessment, including:
    - Services intake,
    - Assessing client needs,
    - Gathering documents for eligibility determinations,
    - Conducting reassessments, and
    - Documenting activities;
- Service Plan development, including:
    - Developing the plan with the client,
    - Writing the plan,
    - Determining who will provide services,
    - Obtaining signatures, and
    - Documenting service plan development;
- Referral, monitoring, and follow-up, including:
    - Various connections to other services, and
    - Coordination of those services;
- Individual counseling;
- Pre-tenancy supports, including:
    - Finding and applying for housing,
    - New tenant orientation and move-in assistance,
    - Landlord advocacy, and
    - Securing household supplies and furniture; and
- Tenancy supports, including:
    - Coaching on relationships with landlords and neighbors,
    - Support with household activities,
    - Early identification of issues or problem behaviors,
    - Education on tenant rights and responsibilities, and
    - Other connections to community resources for the purposes of maintaining housing.

Though most providers offer a majority of the services recommended for evidence-based supportive housing interventions, many providers are unable to bill for much of their work. Providers noted that most, if not all, of these services are billable only if provided through a behavioral health licensed specialist for individuals with SMI (adults) or SED (children), or through a CSA. These services must also be delivered face-to-face with the client in order to be billable. Additionally, though service providers identified these categories as billable (though only 20% identified Tenancy

and Pre-tenancy Supports as billable), all expressed frustration with the fact that if their staff conduct these services outside the presence of the client, they are unable to bill for them. Overall, partial coverage of these services is a significant challenge for the providers interviewed.

The interviews also highlighted several gaps in supportive housing services that are being provided by the interviewed providers. The following services were not provided directly by most supportive housing providers interviewed:

- Many support group services, including:
    - Recreation,
    - Group therapy,
    - Social support, and
    - Conflict resolution training;
- Job skills and training, including:
    - School connections,
    - Academic support, and
    - GED access;
- Domestic violence interventions; and
- Respite care, including:
    - In-home care, and
    - Out-of-home care.

Some providers shared that they would like to offer more services such as job skills and training, yet are limited in their funding.

2. Provider Perceptions about Medicaid Coverage of Supportive Housing Services in NM

By understanding the disconnects between how the State defines or intends services to be delivered and how the provider perceives their ability to offer or deliver the services, the State will be able to efficiently target technical assistance and training to improve the system.

At least 60% of the supportive housing providers interviewed by CSH reported that they did not believe *or* were unsure if the following services were covered by Medicaid in New Mexico's State Plan:

- Transportation;
- Pre-tenancy supports;
- Tenancy sustaining supports;
- Entitlement assistance and benefit counseling;

- Job skills training and education; and
- Reengagement.

Providers also identified that case management and supportive housing services are not currently covered for individuals with a primary diagnosis that is other than an SMI or HIV/AIDS (i.e. primary substance use disorder or primary medical illness).

3. Provider-Identified Gaps in Covered Services and Reimbursement

This section includes provider comments about services they understand are covered by Medicaid but for which reimbursement levels do not align with the amount of time needed to deliver the services or the staffing needs for quality services.

Providers seemed to have concerns with the level of funding they were able to leverage from Medicaid to cover the costs related to those billable services they are providing. To illustrate, providers pointed mostly to administrative costs related to the covered services, and the fact that face-to-face reimbursement did not cover the full amount of time spent providing services. In all cases, as mentioned below, providers must cover additional costs with other sources of funding. Transportation, for example, requires often upwards of 20% of their employee time, but must be covered with alternative sources of funds. In addition, a few providers noted that some even more ancillary tasks like data reporting and paperwork for various State programs are not well covered by the reimbursement rates for the services involved. Several providers offered the idea of switching to a case rate for reimbursement as a way to help them cover their costs more efficiently.

One provider noted that screening for housing services is only reimbursable for SMI populations, which means that as they screen people to enter State housing programs like Linkages, they can only bill for those individuals they will be able enroll in the housing programs who have a SMI. This provider believed it would be helpful to have all housing screenings covered, as a billable service for chronically ill individuals and those with substance use disorders, regardless of SMI diagnosis.

4. Non-Medicaid Sources of Funding

All service providers interviewed covered some of the cost of their services through other means than Medicaid. Types of funds used include:

- HUD Grants;
- SAMHSA Grants;
- Linkages program, through NM HSD;
- City of Albuquerque funds;

- Bernalillo County funds; and
- Other fundraising.

Fifty percent (50%) of supportive housing service providers interviewed did not bill Medicaid at all, and relied solely on these alternative sources of funding. All service providers who have so far not been billing Medicaid (either at all, or for particular services) did express interest in billing should the opportunity arise, and should the billing structure mean it would make fiscal sense to do so. Currently, the extra administrative costs of trying to build up capacity to bill were unappealing to many providers. Some posited that the amount of money billing would bring in would not cover their costs enough to merit expanding services or adjusting their employee titles to come into line with current state requirements.

Some providers were also unsure if they would be able to become a billing agency at all; reporting a perception that the number of organizations that can bill most of the supportive housing services has been kept limited, adding that they believe an existing agency would need to be removed as a particular provider type before another agency could be added.

IV. CSH Recommendations

The state of New Mexico is making strides to create a system of integrated care that meets the needs of the whole person, including addressing population health. In order to realize the improved health outcomes and potential cost savings that result from supportive housing, CSH recommends the following for New Mexico's leadership, providers, advocates, and consumers.

A. Create a Supportive Housing Services Benefit in New Mexico's State Plan.

Supportive Housing Services should be explicitly included in the New Mexico State Plan using the CMS guidelines of pre-tenancy and tenancy-sustaining services included in the Informational Bulletin released on June 26, 2015. These services, if outlined specifically in the State Plan, could be clarified as services included in case management or CCSS services through a State Plan Amendment, or they could be included as a unique Supportive Housing Services benefit through an 1115 Demonstration Waiver under Centennial Care. This benefit, similar to peer support services, would have its own certification process, allowing supportive housing service providers outside of the CSA, CMHC, and FQHC provider community to become certified and begin billing Medicaid for supportive housing services.

This work would include fully researching the cost benefit analysis of creating a benefit. In so doing, New Mexico should reference and build on the cost benefit analysis underway as part of the PFS feasibility process referenced in the introduction to this report. Washington State, a member of the same PFS feasibility cohort as New Mexico, has been pursuing a Supportive Housing Services Benefit as part of their larger 1115 Waiver application. Washington conducted cost modeling to approximate what the budget neutral cost of a case rate would be for their populations of interest, which are largely the same as those highlighted in this Crosswalk. The modeling estimates that a case rate of about $550 per member per month, would likely cover about 5 hours of services, and is budget neutral, with the possibility of creating savings for reinvestment. A theoretical cost analysis for a supportive housing services benefit for New Mexico has been included as Appendix B. This analysis models a case rate of $450 based on the significantly lower costs included in the study conducted for by the University of New Mexico Institute for Social Research on the cost and benefits of housing the homeless in the city.

Pursuing a benefit can happen in a number of ways, including being managed by physical and behavioral health care as well as through long term services and

supports. Once a benefit is in the works, however, staff must develop services definitions (often taken directly from the CMS Informational Bulletin), make adjustments to the rules and regulations allowing those services to be delivered, as well as create licensing procedures that will allow the best providers already delivering services to become licensed to bill for the new benefit. Engaging stakeholders like service providers, MCOs, and advocacy organizations throughout the process has been important for Washington in terms of clear messaging around the benefit and what it adds to the possibility of billing.

B. Cover and expand supportive housing and case management services to include individuals with Substance Use Disorders.

Supportive housing is recognized as an appropriate platform for providing addiction treatment services. A Supportive Housing Services benefit (explained in Recommendation A) should target not only individuals with severe and persistent mental illness, but also individuals who are chronically homeless with substance use disorders or drug-related criminal histories, multiple chronic health conditions or a single chronic health disorder, if severely unmanaged and causing frequent hospitalizations. The continuum of treatment options for individuals with substance use disorders must be expanded to include those that are homeless and actively using. Supportive housing services can improve the integration of behavioral and physical health care services and promote the collaboration between treatment providers and homeless system providers. This integration can be accomplished through a waiver that carves out supportive housing services for individuals with substance use disorders that are actively using, experiencing homelessness, and cycling in and out of emergency and crisis service systems (jails, prisons, shelters, hospitals, and detox facilities).

C. Provide training to all stakeholder organizations on the role of supportive housing as a health intervention.

Training should be supported for all managed care organizations and traditional health and behavioral health organizations looking to learn more about supportive housing services available for Medicaid clients. Managed care organizations can play a helpful role in facilitating shared learning and partnerships with the community-based agencies providing housing and supportive housing services for their members. Supportive housing services provide integrated care for the whole-person as care coordination involved all crisis service systems, including emergency services, primary and behavioral health care, housing and homeless system services and addiction treatment services. All providers within these systems need to be

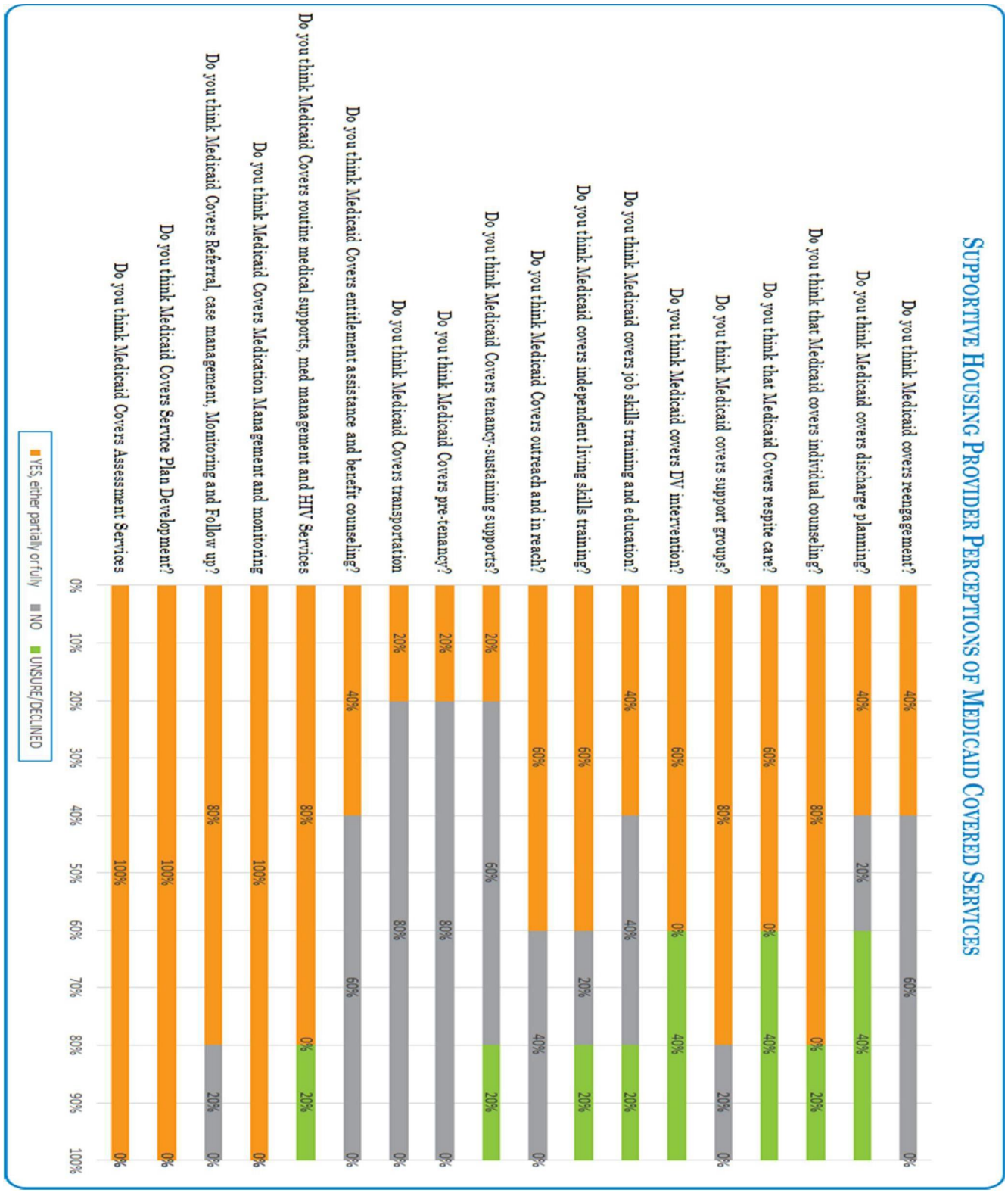
included in training to support and promote care coordination.

Training should also be supported for rural supportive housing providers on promising practices in providing supportive housing services to individuals in rural communities. Some of these promising practices were highlighted at the 2016 CSH Summit Rural Track and include 1) the use of peers and generalized staffing positions so that services provided by general supportive housing case management staff are based on geography rather than specialty service, 2) lowering client to case manager ratios to accommodate longer travel times 3) reinvesting savings from decreased emergency department use from supportive housing into rural supportive housing services, and 4) tenancy support services to include psychosocial skill development, community integration, and family reunification so that individuals become better connected into local support systems like faith-based and neighborhood groups in rural settings.

D. Provide community trainings on how to become a biller of CCSS services.

Finally, CSH recommends that supportive housing advocates support training for supportive housing providers to become Medicaid billers, including training on State processes for becoming licensed and certified provider agencies and training on working with MCOs within New Mexico's Centennial Care program.

Appendix A: Provider Interviews, Perceptions of Medicaid Coverage



APPENDIX B: NEW MEXICO SUPPORTIVE HOUSING SERVICES BENEFIT THEORETICAL COST ANALYSIS

CoC Name	Total Homeless	Sheltered Homeless	Unsheltered Homeless	Homeless Individuals	Sheltered Homeless Individuals	Unsheltered Homeless Individuals	Homeless People in Families	Sheltered Homeless People in Families	Unsheltered Homeless People in Families	Chronically Homeless
Albuquerque CoC	1,254	1,110	144	868	726	142	386	384	2	200
New Mexico Balance ofState CoC	1,492	1,208	284	936	703	233	556	505	51	509
	2,746	2,318	428	1,804	1,429	375	942	889	53	709
*Data from 2014 Point in Time Count										

New Mexico Supportive Housing Services Benefit Theoretical Cost Analysis		
Total number of chronically homeless in NM from 2014 PIT count: 709	"Super Users" in the top decile of Medicaid costs are estimated as 15% of the 709 chronically homeless, or 106 beneficiaries.	
Average annual health care costs per individual are estimated at $30,000 based on data from 4 states. (1)	**Estimated Cost per Individual**	**106 Individuals**
A. Monthly Medicaid Costs (average annual costs divided by 12)	$2,500	$265,875
State Share of Medicaid Costs (29% State/71% Federal)	$725	$77,104
B. Supportive Housing Cost Reduction Estimate	24%	24%
C. Monthly Medicaid Offsets Projected from Supportive Housing (A*B)	$600	$63,810
State Share of Monthly Offsets from Supportive Housing	$174	$18,505
D. Monthly Cost of Supportive Housing Services Benefit in NM (2)	$450	$47,858
State Share of Cost of Supportive Housing Services Benefit	$131	$13,879
E. Net Monthly Savings (C-D)	$150	$15,953
State Share of Net Monthly Savings	$44	$4,626
F. Net Annual Savings (E*12)	$1,800	$191,430
Net Annual State Savings	**$522**	**$55,515**
G. Return on Investment	33%	
(1) Estimate is based upon pre-housing Medicaid costs of high utilizers who were chronically homeless in Washington State; Chicago, IL; Massachusetts; and Los Angeles, CA.		
(2) Estimate of Supportive Housing Services monthly costs based on national estimates		