VERMONT

**Vermont Medicaid PSH Assistance Program**
**DRAFT Provider Manual**
*Updated: February 2025*

# Table of Contents

# PROVIDER MANUAL PURPOSE

This provider manual is intended to provide guidance for agencies delivering services under the Vermont Medicaid Permanent Supportive Housing Assistance (PSHA) Program for eligible Medicaid members in Vermont.

The manual includes detailed information about the required scope of services; standards for service delivery; reimbursement and reporting requirements; eligibility and prioritization criteria; outreach activities; and expectations for coordination and collaboration with Vermont state case managers and other provider agencies.

# SECTION I: PROGRAM DESIGN AND OPERATIONS

## Program Overview

Permanent Supportive Housing (PSH) is an evidence-based intervention that has been demonstrated to be effective in reducing homelessness, preventing emergency department use and hospitalization, and reducing overall healthcare costs for individuals with high needs.

The Vermont Medicaid Permanent Supportive Housing Assistance (PSHA) Program (the Program), which is authorized by Vermont's Global Commitment to Health 1115 Demonstration Waiver, is intended to support PSH services that help Vermonters with complex health and social needs to successfully transition into and maintain residency in permanent housing.

Benefits available through the Program are based on health needs and risk-based eligibility criteria and fall into the following three categories:

- **Pre-Tenancy Support Services** – Pre-tenancy support services are a set of services that assist Participants with finding and securing appropriate housing.

- **Tenancy Sustaining Services** – Tenancy sustaining services are a set of services that support Participants' ability to meet their obligations as tenants and maintain their tenancy.
- **Community Transition Assistance**– Community transition assistance aids Participants with funding the one-time services, goods, expenses, and modifications necessary for them to successfully move into housing and establish a basic household.

The Program leverages a Conflict-Free Case Management approach, described below, to ensure that the PSHA services provided for each Participant are grounded in an independent, “conflict-free,” person-centered care plan that addresses the Participant’s whole-person needs, as required by federal regulations. The Program is also explicitly intended to align with Vermont’s existing PSH models and other housing programs so as to effectively leverage limited resources and make available an array of high-quality services for Vermonters with complex needs.

The Vermont Office of Economic Opportunity (OEO) in the Department of Children and Families is responsible for Program management and quality assurance (QA). OEO implements Conflict-Free Case Management for The Program.

## Conflict-Free Case Management

The Program is authorized as a Medicaid Home and Community-Based Services (HCBS) program, a program type that was created to provide opportunities for Medicaid Participants to receive services in their own home or community rather than in an institution or similar setting. Federal rules attached to HCBS programs require that an independent, “conflict-free,” person-centered care plan be developed for each Medicaid Participant served through an HCBS program. Such rules mean that a Medicaid Participant’s person-centered care plan cannot be completed by anyone who works for the organization that will provide direct services for them under the same program. Such care plans also cannot be completed by anyone who is related to the Medicaid Participant by blood or anyone who is financially responsible for them or legally empowered to make decisions on their behalf.

The Program uses a Conflict-Free Case Management (CFCM) model to ensure compliance with these HCBS requirements. The CFCM model is critical in that it enables the agencies contracted to provide direct services under the Program (Contracted Providers) to concentrate on identifying and meeting the Participant’s housing-related needs, while CFCM case managers in OEO coordinate referrals to the Program and focus on care planning that addresses the Participant’s broader “whole-person” priorities and concerns. The goal of CFCM as it is implemented here is to ensure that all Program housing services are delivered in the context of the “whole person” and that each Participant’s “whole-person needs” are known to and addressed by the Program or specifically attended to with other community partners.

Within this framework, CFCM case managers in OEO are responsible for carrying out the following tasks:

- Coordinating with local Coordinated Entry Lead Agencies to request referrals.

- Verifying Medicaid enrollment and determining and documenting that the Participant is eligible for Program services according to the established eligibility criteria.

- Managing the Medicaid prior authorization and re-authorization processes for eligible Participants.

- Securing a release of information from each eligible Participant to enable sharing of protected personal information for referrals to Contracted Providers, housing search, and case conferencing activities.

- Conducting a whole-person assessment of need with each eligible Participant and then working with the Participant to develop a person-centered CFCM Care Plan that incorporates the total needs of the Participant, including but not limited to their medical, mental health, and substance use disorder needs, as well as the Participant's needs for functional and community support and their personal goals and priorities.

- Referring eligible Participants to Contracted Providers based on established prioritization criteria and Contracted Provider capacity.

- Working flexibly and collaboratively with the Contracted Provider to ensure that all plans developed, and all services delivered under the Program remain aligned with Participant needs and priorities, including as those needs and priorities evolve.

- Reviewing and approving requests for Community Support Transition funds, as appropriate.

- Reviewing and updating the CFCM Care Plan with the Participant at least annually, when the Participant's needs and circumstances change significantly, or at the request of the Participant.

- Assessing the Participant's progress towards achieving the goals identified in their person-centered CFCM Care Plan, as well as their readiness to transition out of the Program (i.e., to a lower level of care delivery), as appropriate.

The expected caseload size for CFCM is 50-75 Participants.

Note that CFCM is not intended to and should not replicate any of the services provided by Providers, i.e., pre-tenancy supports, tenancy sustaining services, or community transition assistance. The scope of services for Contracted Providers under the Program is described in Section II: Scope of Services (p. 8).

## Eligibility and Prioritization Criteria for Individuals Receiving Services

To be eligible for Vermont Medicaid PSH Assistance services, individuals must be:

- Enrolled in Vermont Medicaid
- Age 18 or older
- Eligible for full Medicaid State Plan benefits

Eligible individuals must also demonstrate at least one of the following health needs **and** meet at least one of the following risk-based criteria:

| Health Needs Criteria | Risk-Based Criteria |
|---|---|
| ▪ Mental health need, where there is a need for improvement, stabilization, or prevention of deterioration of functioning (including ability to live independently without support) resulting from the presence of a serious mental illness<br>▪ Substance use need, where an assessment using the American Society of Addiction Medicine (ASAM) criteria indicates that the individual meets at least an ASAM level 1.0, indicating the need for outpatient Substance-Use Disorder (SUD) treatment<br>▪ Assistance with one or more activities of daily living (ADLs), instrumental activities of daily living (IADLs), or other daily life skills | ▪ At risk of homelessness, as defined by AHS/HUD<br>▪ History of homelessness, as defined by AHS Housing Policy<br>▪ History of frequent or lengthy stays in institutional or residential settings<br>• Frequent is defined as one or more stays in the past 12 months<br>• Lengthy is defined as 28 or more consecutive days<br>▪ History of frequent Emergency Department (ED) visits and/or hospitalizations<br>• Frequent is defined as two or more visits within the past six months or four or more visits within a year<br>▪ History of involvement with the criminal justice system over the past 12 months |

| | |
|---|---|
| resulting from the presence of an acquired brain injury.<br>▪ Individual assessed to have a need for assistance, demonstrated by the need for assistance with two or more ADLs; or hands-on assistance with one or more ADL.<br>▪ Individual assessed to have a complex physical health need, where there is a need for improvement, stabilization, or prevention of deterioration of functioning (including the ability to live independently without support), resulting from the presence of a continuing, progressive, or indefinite physical condition, development, or cognitive disability, or an emotional medical condition.<br>▪ Individual assessed to have measurable delays in cognitive development and significant observable and measurable delays in at least two of the following areas of adaptive behavior: communication, social/emotional development, motor development, daily living skills. | ▪ History of frequent moves or loss of housing as a result of mental health or SUD symptoms<br>• Frequent is defined as one or more moves /loss of housing due to mental health or SUD symptoms in the past six months<br>▪ At serious risk of institutionalization due to the lack of available community supports. |

Note that individuals who are eligible for full State Plan benefits and are enrolled in Choices for Care or one of Vermont's special programs defined in 4.4(c) (i.e. Developmental Disabilities Services, Brain Injury Program, or Mental Health Under 22) are eligible for the Program; however, these individuals cannot obtain any services or supports from the Program that duplicate services they already receive.

Similarly, participants may be concurrently enrolled in mental health services through their local designated agency, but steps must be made to ensure that services are not duplicative. Most DAs offer housing supports as part of their Community Support services. If a participant is already receiving this and feels their needs are being met, they would not be able to also receive PSHA. If they specifically chose to receive PSHA

with a different provider or the DA is unable to meet the complex service needs related to targeted housing supports, they can be enrolled in both. A note should be made of this in the service plan.

Participants will be prioritized for available PSHA slots based on their priority position for Permanent Supportive Housing (PSH) as established by each Continuum of Care (CoC). Once interest is verified, the Coordinated Entry Lead Agency will refer individuals to the Program in the order of their established priority for PSH. Once their Program eligibility is confirmed by CFCM, such potential Participants will maintain their priority based on the order they were referred to the Program. Prioritization standards for each CoC can be found in the CoC's CE Policies and Procedures. Based on current CE PSH prioritization criteria, households prioritized for referral will be chronically homeless according to the definition established by the Department of Housing and Urban Development (HUD).

Serious Mental Illness, SMI, is the identification of a mental health diagnosis that results in functional impairment which substantially interferes with or limits one or more major life activities.

OEO will work with Contracted Providers to develop a referral protocol if situations arise in which no households exist within the CoC Coordinated Entry (CE) system that meet the chronic homeless definition as well as a referral protocol to allow for households meeting the HUD "at risk of homelessness" definition if capacity permits, such as during the ramp-up period for a new Contracted Provider.

## Eligibility Criteria and Qualifications for Contracted Providers

The State will select providers through a Request for Proposals. Selected providers must have experience providing similar services and supports. Eligible provider types include but not limited to: Community Mental Health Centers/Certified Community-Based Integrated Health Centers (also known as Designated Agencies/Specialized Service Agencies); Permanent Supportive Housing (PSH) Providers; Health Care for the Homeless Programs (HCHPs)/Federally Qualified Health Centers (FQHCs); Designated Preferred Providers for the Division of Substance Use Programs, and Housing and Homelessness Services Providers.

Any agency that serves as a Contracted Provider must be able to clearly demonstrate that they possess the following experience and expertise:

- Strong track record of helping people remain stably housed, or a clear ability to do so in the future.
- Experience working successfully with both tenants and landlords, including both public housing agencies and private market landlords.
- Familiarity with affordable housing programs and processes in Vermont, including but not limited to housing voucher programs, public housing authorities, and other systems and resources.
- Deep knowledge of the array of existing services available to support the sustainability of housing, including experience providing housing search and tenancy support services. Examples of skills critical to such services include but are not limited to; housing navigation, service coordination, coaching, and motivational interviewing.
- Commitment to and plan for providing high quality services to all individuals and families so that everyone feels welcome, well-served, and supported regardless of their race, ethnicity, sexual orientation, gender identity and expression, intellectual or physical ability, English language proficiency, or life experiences.
- Capacity to provide culturally and linguistically responsive and trauma-informed services.
- Capacity to provide services that are grounded in harm-reduction, person-centered care, and assertive engagement models.
- Capacity to take a flexible approach to service delivery that is responsive to the unique housing sustainability needs of individuals and families.
- Experience with and/or commitment to Housing First principles.
- Capacity to empower tenants, through education, about their rights and responsibilities.
- Capacity to quickly respond to concerns and requests from Participants and/or landlords to resolve problems (including eviction actions) before they become a crisis.
- Participation in the local Continuum of Care or Housing Coalition, or the capacity and willingness to do so upon contracting.
- Strong recordkeeping abilities, or the capacity to quickly develop strong recordkeeping abilities, including but not limited to the ability to document that they have met the minimum level of service delivery required for monthly Medicaid billing (see p. 26)

Contracted Providers must enter into a signed Agreement with the Department for Children and Families and must enroll as a Medicaid Provider in Vermont.

# SECTION II: Standards for Service Delivery

## Service Definitions

The Medicaid PSH Assistance Program includes three distinct services:

- Pre-tenancy support services
- Tenancy sustaining services
- Community transition assistance to support permanent housing

Each service is described in more detail below. Contracted Providers must provide all three services for the Participants referred to them, as appropriate.

Note that Program services do **not** include the provision of room and board or the payment of rental costs.

- **Pre-Tenancy Support Services –** Pre-tenancy support services are a set of services that assist Participants with finding and obtaining appropriate housing. Pre-tenancy support services may include any of the following:

    - Conducting a standardized housing assessment that identifies the Participant's housing needs and preferences and any barriers related to finding and moving into housing, as well to successfully maintaining their tenancy. (Requirements for standardized housing assessments are detailed on p. 16).

    - Developing an individualized Housing Search Plan with the Participant that addresses the barriers, needs, and preferences identified in the housing assessment. (Requirements for Housing Search Plans are detailed on p. 17).

    - Identifying and securing available resources to assist with subsidizing rent (for example, HUD's Housing Choice Voucher Program or state and local assistance programs), as appropriate, based on rental subsidy eligibility and priority criteria and the Participant's unique characteristics and circumstances.

    - Searching for housing that is consistent with the Participant's identified preferences and presenting housing options to the Participant.

- Developing and leveraging relationships with local landlords preparing to present information on PSHA services, VSHA's Landlord Relief Program, the state's Weatherization Program, and other benefits to renting to low income or previously homeless households.

- Setting up visits to view available housing units, including scheduling appointments and assisting the Participant to secure transportation, childcare, or other supports they may need to participate in the housing visit.

- Assisting the Participant to secure housing, including helping them complete housing applications and assemble the documentation required for them to become housed (e.g., Social Security card, prior rental history).

- Assisting the Participant with benefits advocacy, including providing assistance with obtaining identification and documentation for SSI/SSDI eligibility and supporting the SSI/SSDI application process. (Note that such services may be subcontracted out to access the specialized skill set(s) required for these tasks).

- Identifying, securing, and coordinating resources to cover expenses such as security deposits, moving costs, adaptive aids, environmental modifications, moving costs, and other one-time expenses associated with moving into the housing unit. Note that funding for such expenses may be available to the Participant through the Program's Community Transition Assistance (see page 14 for guidelines); however, funding through Community Transition Assistance should be requested only if no other funds are reasonably available.

- Completing applications for funding available to the Participant through Community Transition Assistance, as needed and appropriate, including securing proper documentation to support the request.

- Assisting the Participant with requests for reasonable accommodation, if necessary.

- Ensuring that the living environment is safe and ready for move-in.

- Assisting the Participant with arranging for and supporting the details of the move to the housing unit.

- Establishing procedures and contacts designed to support the Participant in retaining their housing, including developing a Housing Support and Crisis Plan that includes prevention and early intervention services when housing is jeopardized. (Requirements for Housing Support and Crisis Plans are detailed on p. 17).

- Communicating and advocating on behalf of the Participant with landlords.

- Engaging in ongoing landlord education and relationship-building, including work with individual landlords and coordination with landlord incentive programs, tenant education initiatives and similar groups and resources. (Note that the Participant must provide written permission for any outreach to individual landlords or program undertaken explicitly on their behalf).

- Taking steps to build connection and establish and strengthen a trusting relationship with the Participant, per the principles of Assertive Engagement.

**Duration:** Service duration may continue until services are no longer needed by the Participant, as documented in their person-centered CFCM Care Plan, contingent on determination of continued Program eligibility.

- **Tenancy Sustaining Services** – Tenancy sustaining services are a set of services that support the Participant's ability to meet the obligations of tenancy and successfully maintain their housing. Tenancy sustaining services include the following:

    - Working with the Participant and (with the Participant's consent) others involved in the Participant's care and support (including CFCM case managers), to help the Participant establish and maintain connections with community resources that can address core issues that may impact their ability to remain stably housed, including but not limited to mental health and substance use disorder providers, primary care providers and specialist providers, peer supports, job training, legal assistance, and others. Such efforts may include scheduling appointments and accompanying the Participant to appointments, as needed and desired by the Participant, and liaising with CFCM case managers to address newly emerging Participant needs.

- Engage with the Participant to review, update, and modify their existing Housing Support and Crisis Plan on a monthly basis in the first six months after becoming housed and on a semi-annual and as needed basis thereafter to ensure that the plan reflects the Participant's current needs, preferences, and priorities and addresses both new and recurring barriers to housing stability.

- Assisting the Participant to connect with opportunities for socialization, vocation, recreation, and community integration and participation so that they may develop natural supports that can aid in housing stability.

- Meeting with the Participant on a regular basis to ensure early identification of and intervention in behaviors that may jeopardize the Participant's housing, such as late rental payment, hoarding, substance use, and other lease violations.

- Assisting the Participant to develop independent living and life skills including but not limited to budgeting, financial literacy and personal finance, housekeeping, grocery shopping, meal preparation, and personal hygiene.

- Educating the Participant on the role, rights, and responsibilities of the tenant and the landlord.

- Coaching the Participant on developing and maintaining positive relationships with landlords and property managers, with the goal of fostering a successful tenancy.

- Coordinating with the landlord and others involved in providing care and support for the Participant, as appropriate and with the Participant's consent, to address identified issues that could impact housing stability.

- Assisting in resolving disputes with landlords and/or neighbors to reduce the risk of eviction or other adverse actions, including developing a repayment plan or identifying funding in situations in which the Participant owes back rent or payment for damage to the housing unit.

- With the Participant's consent, linking the Participant to community resources that can help prevent eviction when their housing is or may potentially become jeopardized.

- Assisting the Participant to pursue and maintain public benefits that can help support their housing stability and overall health wellbeing, including providing assistance with obtaining identification and documentation for SSI/SSDI eligibility and supporting the SSI/SSDI application process, and providing assistance with enrolling and maintaining enrollment in benefits including but not limited to 3 Squares, Medicaid, TANF, and others. (Note that such services may be subcontracted out to retain the required specialized skillset(s)).

- Assisting with the annual housing recertification process to enable the Participant to retain their housing voucher, as applicable.

- Providing ongoing assistance with lease compliance, including ongoing support with activities related to household management.

- Assisting with reasonable accommodation requests that were not initially required at move-in.

- Activating the Participant's housing crisis plan, as appropriate.

- Conducting regular health and safety visits, as applicable and as aligned with the agency safety policies.

- Taking steps to build connection and establish and strengthen a trusting relationship with the Participant, per the principles of Assertive Engagement.

**Duration:** Service duration may continue until services are no longer needed by the Participant, as documented in their person-centered CFCM Care Plan, contingent on determination of continued Program eligibility.

- **Community Transition Assistance**– Community transition assistance provides funding for one-time services, goods, expenses, and modifications necessary to enable the Participant to establish a basic household.

  Community transition assistance is available to Participants per the approval of the CFCM case manager based on an application for such services. Contracted Providers are expected to complete such applications, including securing proper documentation to support the request, on behalf of the Participant, as needed

and appropriate, as part of the Pre-Tenancy Support Services or Tenancy Sustaining Services they deliver for the Participant.

Community transition assistance includes the following:

- Security deposits required to obtain a lease on new home.
- Set-up fees/deposits for utilities or service access and/or utility arrearages (capped at 6 months total).
- First month coverage of utilities, including but not limited to telephone, gas, electricity, heating, and water.
- Moving costs.
- Essential household furniture.
- Pest eradication. Other services necessary for the individual's health and safety, may be made available in the future

Community Transition Assistance must be clearly identified as reasonable and necessary in the Participant's individualized Housing Search Plan and may be accessed only when the Participant is unable to cover the relevant expense using other resources. Services and goods are available one-time only within the Participant's lifetime. Funds for a housing deposit may be approved one additional time so long as the request includes documentation that describes why the Participant's second attempt at housing is more likely to be successful (e.g., what conditions have changed). The Participant must be receiving Pre-Tenancy Support Services or Tenancy Sustaining Services to be eligible for Community Transition Assistance.

## Service Delivery Approach

All services provided under the Program must be based on an individualized assessment of the needs, strengths, preferences, and priorities of the Participant and should clearly reflect the Participant's preferences and priorities.

Participants may require and access only a subset of the services listed above. Participants may also choose to access all, some, or none of the services available under the Program according to their own preferences and priorities.

Contracted Providers are expected to embrace the following service models, which have been shown to be effective for individuals who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions:

- **Housing First** – An approach to housing services that endeavors to quickly connect individuals and families experiencing homelessness to permanent housing without preconditions or barriers to entry, such as sobriety, treatment, or service participation requirements. Supportive services are offered to maximize housing stability and prevent returns to homelessness as opposed to addressing predetermined treatment goals prior to permanent housing entry.

- **Harm Reduction** – A model of substance-use intervention that focuses on helping people to better manage substance use and reduce the harmful consequences of substance use to themselves and others, including working to prevent evictions. The harm reduction philosophy means that individuals do not have to be sober to be eligible to enter housing and are not evicted solely for a failure to maintain sobriety.

- **Trauma-Informed Care** – An approach to care that acknowledges the impact of trauma on people seeking services. Under this approach, services are designed and delivered in such a way that they emphasize safety, trustworthiness, client choice, collaboration, and empowerment.

- **Person-Centered Care** – An approach in which engagement in services is voluntary, customized, and comprehensive, reflecting the individual needs and preferences of people experiencing homelessness.

Contracted Providers are also expected to embrace best practices for providing care and support for individuals who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions, including but not limited to:

- **Assertive Engagement** – A person-centered approach that leverages the interpersonal skills and inventiveness of direct service providers to engage individuals and interest them in subsequent services and supports. Assertive engagement is useful for individuals who struggle with or reject services that demand their pro-active engagement. Instead, assertive engagement places the onus on service providers to build connection and relationships persistent and consistently. The approach entails taking multidisciplinary services directly to individuals and providing ongoing support.

- **Motivational Interviewing** – A person-centered approach to counseling that focuses on exploring and resolving ambivalence and centers on motivational processes within the individual to facilitate change.

Program services must be accessible to and sensitive to the needs of Participants whose primary language is not English. Program service delivery must consistently demonstrate linguistic and cultural competence and should strive to honor all individuality, including but not limited to race, religion, ethnicity, sexual orientation, gender identity, and financial status.

All service delivery and support strategies implemented under the Program must incorporate the principles of empowerment, community inclusion, health and safety assurances, and the use of formal, informal, and community supports. All Program staff, including leaders, managers, and direct service staff, are expected to adhere to person-centered, trauma-informed, harm-reduction, and Housing First principles during all planning, coordination, and monitoring activities conducted under the Program.

## Service Planning

Service planning involves working with the Participant, the Participant's legal guardian and/or their authorized representative, and others whom the Participant identifies, such as family members, other service providers, or peers, to complete or develop the following required planning documents:

- Standardized Housing Assessment
- Housing Search Plan
- Housing Support and Crisis Plan

Contracted Providers may utilize a single planning document or multiple separate planning documents to fulfill this requirement, so long as the selected format captures the information and adheres to the timelines outlined below. The service delivery models and best practices must be clearly reflected in all planning documents developed for Participants under the Program.

Note that all planning documents must be grounded in and consistent with the person-centered CFCM Care Plan developed for the Participant. CFCM and Contracted Provider teams are expected to work together flexibly and collaboratively to ensure that all person-centered plans are developed and updated via the minimum number of steps possible for each eligible Participant.

- **Standardized Housing Assessment** – The standardized housing assessment is intended to identify the Participant's housing preferences and priorities, as well as

potential barriers to a successful housing search and tenancy for the Participant. Completed standardized housing assessments should serve as the basis for the Housing Search Plan and Housing Support and Crisis Plan developed for each Participant. Contracted Providers may utilize any format they choose for the standardized housing assessment; however, all standardized assessments must capture the information needed to address all required Housing Search Plan and Housing Support and Crisis Plan elements, as outlined below.

Contracted Providers are required to complete the standardized housing assessment with the Participant within 30 calendar days of Participant enrollment in the Program.

- **Housing Search Plan** – Housing Search Plans are intended to outline a clear plan for assisting the Participant to locate and secure appropriate housing. Housing Search Plans must describe how the Contracted Provider will assist the Participant to overcome identified barriers to becoming housed, as well as demonstrably reflect Participant preferences and priorities. Contracted Providers may utilize any format they choose for the Housing Search Plan; however, all Housing Search Plans developed under the Program must include the following elements:

    - Community or region in which the Participant prefers to be housed.

    - Household Participants in addition to the Participant who need to be housed, including ages and relationship to the Participant, as appropriate.

    - Identification of rent payment options and need to apply for subsidies or vouchers, SSI/SSDI, and/or exploring employment as needed.

    - Any health/disability-related conditions of the Participant or household that may impact housing needs – for example, asthma, mobility issues, etc.

    - Any other unique needs or preferences that may impact housing options– for example, pets, need to be close to a particular healthcare provider or family member, etc.

    - Documentation that the Participant needs to obtain in order to become housed – for example, birth certificates, social security cards, etc.

    - Known obstacles to becoming housed – for example, history of evictions or convictions, outstanding rent payments, having negative relationships with well-known landlords, etc.

- Supports that may be needed for the Participant to participate in the housing search process – for example, assistance with transportation or childcare.

- One-time purchases and services that may be needed to move into housing and to establish a household – for example, first and last month's rent, essential household furnishings, medically-adaptative goods such as a medical bed or air conditioner, etc.

- Known obstacles to remaining housed – for example, substance use disorder (SUD) or mental health concerns, chronic homelessness, no source of income, etc.

Housing Search Plans must clearly outline goals and action steps for addressing the Participant's known obstacles to becoming housed. Housing Search Plans must also include a timeline for completing key steps in the housing search process, including but not limited to: identifying housing options, scheduling housing visits, applying for rental subsidies, signing up for housing waitlists, and submitting housing applications.

Contracted providers are required to complete a Housing Search Plan in collaboration with the Participant within 45 calendar days of Participant enrollment in the Program. Housing search plans should be updated in collaboration with the Participant on at least a quarterly basis thereafter until the Participant secures housing.

- **Housing Support and Crisis Plan** – Housing Support and Crisis Plans are intended to outline the supports that the Participant needs to successfully manage a household, maintain their tenancy, and provide a clear roadmap for how to address a threat of eviction, should it arise. Housing Support and Crisis Plans must identify the individuals and agencies involved in providing support for the Participant, as well as the individuals and agencies who will be called upon in the event of a housing crisis, should one arise. Housing Support and Crisis Plans must also demonstrably reflect Participant preferences and priorities. Contracted Providers may utilize any format they choose for the Housing Support and Crisis Plan; however, all housing support and crisis plans developed under the Program must include the following elements:

    - Identification of strengths and resources.

    - Known obstacles to successfully managing a household, maintaining a tenancy, and remaining housed, including but not limited to substance use

disorder (SUD) or mental health concerns, association with others who may cause lease violations, no source of or insufficient regular income, a need to improve housekeeping or budgeting skills, and/or a need to gain knowledge about landlord/tenant roles and responsibilities.

- A clear plan for addressing the known obstacles identified that includes both measurable goals and connections to treatment providers, community services, informal supports, and other resources, as appropriate.

- Names and contact information for the individuals and agencies involved in providing services and supports for the Participant, as appropriate and with the Participant's written permission.

- A plan for coordinating and collaborating with the individuals and agencies involved in providing services and supports for the Participant, as appropriate and with the Participant's written permission.

- A crisis plan that will be activated should the Participant face a threat of eviction, including clear steps to be taken to resolve the issue and/or identify alternative housing and the names and contact information of the individuals and agencies who will help to implement the plan, as appropriate and with the Participant's written permission.

- Any personal goals or priorities put forward by the Participant and a plan for achieving them, including by leveraging the efforts of other service providers or accessing natural resources, regardless of whether the goals or priorities directly relate to housing stability.

- A plan for maintaining public benefits including but not limited to 3 Squares, Medicaid, Reach Up, and others.

Contracted Providers are required to complete a Housing Support and Crisis Plan in collaboration with the Participant within 90 calendar days of Participant enrollment in the Program. Housing Support Plans should be updated in collaboration with the Participant on a monthly basis for the first six months after the Participant secures housing and at least every six months thereafter for as long as the Participant receives Tenancy Sustaining Services.

Contracted Providers may begin working with the Participant to implement some or all of the housing support portion of the Plan prior to the Participant becoming housed, as appropriate and in accordance with Participant preferences.

Contracted Providers are expected to ensure that the appropriate releases of information are in place prior to coordination or collaboration with other individuals and agencies involved in the Participant's care.

## Housing Standards Guidelines

The Vermont Medicaid Permanent Supportive Housing Program seeks to support Vermonters to become and remain housed, permanently. In order to do this, we strive to support participants into housing that is permanent, affordable, and safe.
We strongly uphold participant choice and support decisions that are made as long as all potential positive and negative consequences are explored and thoroughly expressed. Contracted Providers are responsible to communicate these things.
Community Transitions Assistance funds (CTA) may only be used when a unit is found to be permanent, affordable, and safe.
Below identifies considerations for recommended minimum housing standards:

- **Lease Agreement** – The Participant will formally enter into a written lease agreement that fits one of the following categories:

    - Standard lease agreement
    - Sponsored lease agreement

  Lease agreements entered into under the Program must be for one year with an option to renew or fold over to month to month, unless a shorter term is the prevailing local practice.

- **Housing Quality Standards** – Housing units for which the Participant will be entering into a lease will at minimum meet all local and Vermont State housing codes.

  If the Participant is utilizing a housing voucher or moving to a unit subsidized through a local, state, or federal program, the Contracted Provider must obtain a copy of the inspection report documenting that the unit meets the housing quality standards specific to the applicable housing program. If a subsidy is not involved, the Contracted Provider may otherwise document habitability standards. *See Appendix A – Habitability Checklist.*

- **Affordability** – Housing units for which the Participant enters into a lease must be "affordable" to the greatest extent possible. Under the best practice standard for

"affordability," no more than 30% of a household's gross income should go towards rent and utilities. Depending on the type of tenant-based subsidy received by the Participant or the subsidized unit leased, the Participant may pay up to 40% of their household's gross income towards rent and utilities.

More information can be found in *Appendix B – PSHA Housing Standards Guidance.*

Footnote: The possible acceptance of rental units outside the preferred housing standards is taken into consideration in response to the severe housing shortage in the State and the resulting understanding that length of time in homelessness may be significantly magnified without such flexibilities. This policy may be amended as conditions change.

## Coordination and Collaboration with Local Entities

Coordination with local entities is crucial to ensure that Program Participants have access to the supports they need to find and secure housing and to successfully remain housed. Such local entities may include but are not limited to medical providers including substance use treatment providers and mental health providers, public health programs, social services programs, services for older adults, local legal service providers, job training programs, community-based organizations, wellness programs, peer supports, and the local Continuum of Care (CoC) and Coordinated Entry System(s) (CE), as well as a wide array of local homeless services agencies, public housing authorities, housing developers, landlords and property managers, and other operators of local rental opportunities and rental subsidies. Close coordination with local CEs, homeless service authorities, public housing authorities, and other operators of local rental subsidies is particularly relevant for Participants who will need rental subsidy support to secure permanent housing. Close coordination with these entities is also imperative to ensuring that available housing and/or rental subsidies are coordinated with the housing services and supports available to Participants through the Program. Contracted Providers are expected to coordinate and collaborate with local Designated Agencies (DAs) and Social Services Agencies (SSAs), as needed and appropriate to ensure that supports are mutually enhancing and not duplicative or confusing to the Participant.

Contracted Providers should already have and/or endeavor to develop extensive connections with local entities so that they are well-positioned to connect Participants to resources that can help them secure housing and successfully maintain their tenancy and to collaborate productively with the other entities and individuals involved in the Participant's care.

Contracted Providers must also meet the following requirements, each of which is intended to facilitate successful coordination and collaboration with local entities:

- Participate in Vermont's Homeless Management Information System (HMIS). HMIS is a software application designed to record and store client-level information on the characteristics and service needs of persons experiencing homelessness or unstable housing within a geographic catchment area. Notably, HMIS includes features that make it easier to share and request client-level information within the secure HMIS environment, thus enabling real-time coordination with any agency that participates in HMIS while ensuring that clients' privacy is protected. Data reports from the HMIS system will align closely with required quarterly and annual reports.

- Participate in the Coordinated Entry System established by their local Continuum of Care (CoC) and develop and maintain collaborative relationships within their Continuum of Care to ensure coordination and effective service delivery for Participants.

- Participate in the annual Point-in-Time Count conducted by their local CoC as required by the Department of Housing and Urban Development (HUD).

- For Participants who are referred to the Program from an institutional setting (e.g., incarceration, hospitals, etc.), participate with the Participant's treatment or case management team in order to identify appropriate available housing units and place the Participant in an affordable, appropriate living environment upon discharge from the institutional setting.

- Engage in Team Based Care or care coordination with Participant and other providers as needed to ensure supportive, collaborative care.

In addition to these requirements, as a general standard, Contracted Providers are expected to adopt, monitor, and continually improve upon practices and approaches that ensure seamless, responsive service delivery for all Participants enrolled in the Program.

## Coordination with Conflict-Free Case Management

Contracted Providers must actively coordinate with the CFCM case manager in all aspects of service delivery under the Program.

At minimum, Contracted Providers are required to meet with the CFCM case manager, either in person or virtually, at least quarterly to discuss progress and challenges for Participants in their caseload. Enhanced engagement may be expected when

Participant needs are particularly complex, or the Participant requests it. Contracted Providers must also provide the CFCM case manager with a copy of each Participant's current housing plan(s), including the plan(s) they initially develop with the Participant and any updated plans.

Contracted Providers are required to provide written notification to the CFCM case manager should any of the events described in the table below occur for any Participant in their caseload. Note that the table also includes examples of the types of actions the CFCM case manager might take in response to the notification, depending on the circumstances.

| **Event Category** | **Events** |
|---|---|
| Discharge | • Contracted Provider is starting to think about needing to discharge a Participant from their services |
| Health/Behavioral Health | • Emergency Department (ED) visit<br>• Hospitalization<br>• Entry into a residential treatment program<br>• New diagnosis of serious medical condition (e.g., cancer, congestive heart failure, etc.)<br>• Pregnancy<br>• Worsening physical or behavioral health condition (written notification at the discretion of the Contracted Provider, based on Contracted Provider observation and/or community/partner agency report)<br>• Death |
| Justice-Involvement | • Incarceration or re-incarceration |
| Level of Care | • Participant is assessed as needing a higher level of care than the PSHA program and coordinated services can provide.<br>• Participant is assessed as being ready to transition to a lower level of care (i.e., out of the PSHA program).<br>• Identified duplication of services with other providers that can't be resolved through coordination. |
| Participant Engagement with Contracted Provider | • There has been no contact with the Participant for thirty (30) days, and the Participant cannot be located.<br>• Incident of violence by the Participant towards a Contracted Provider staff members.<br>• Considerable breach of conduct by a Contracted Provider towards the Participant such as:<br>Verbal or physical aggression<br>Exploitation |

| | |
|---|---|
| Living Situation | • Participant is evicted<br>• Circumstances that may, in the Contracted Provider's judgement, result in an eviction *(e.g., conflict with landlord or neighbors, disruptive behavior, damage to housing unit, etc.)*<br>• Move to another housing unit.<br>• Participant is no longer in the unit due to one of the events noted above *(e.g., extended period of hospitalization, move to long-term residential care, incarceration, etc.)* |

Contracted providers will formally report Critical Incidents to OEO as outlined in the Critical Incident Report policy. Providers may use their own form, or the one provided as long as all necessary information is included. *See Appendix C – Critical Incident Report policy and sample form.*

Lastly, as outlined above, the Housing Plan(s) that Contracted Providers develop with Participants and the Program services they provide for Participants must be grounded in the person-centered CFCM Care Plan developed by the CFCM case manager. Contracted Providers are expected to work flexibly and collaboratively with the CFCM case manager to ensure that all plans and all services delivered under the Program remain aligned with Participant needs and priorities, including as those Participant needs and priorities evolve, and that barriers to Program services are minimized to the extent possible for each Participant.

## Supporting Program Discharges

Planning for discharge from the Program is a collaborative process that Contracted Providers should conduct in partnership with the Participant and with input from any other service provider(s) or case manager(s) involved in the Participant's care. Participants receiving Program services must be informed of the criteria for Program discharge at the time of Program enrollment. Contracted Providers must work with the CFCM prior to any new program discharges.

**Discharge Criteria** – A Participant may be deemed ready for discharge from the Program if one or more of the following circumstances exists:

- The Participant voluntarily elects to discontinue Program services.
- The goals and objectives identified in the Participant's Housing Support Plan have been met, and other circumstances (e.g., tenancy in good standing, Participant is engaged with formal and informal supports outside of the Program) indicate that the Participant can successfully maintain housing stability without Program supports.

- The Participant becomes eligible for and chooses to receive pre-tenancy support or tenancy sustaining services via another federal program.
- The Participant is no longer eligible for Medicaid.
- The Participant presents safety risks for Contracted Provider staff members, including but not limited to sexual harassment and threats of violence.
- The Participant moves out of the Contracted Provider's service area.
- There is a sustained loss of contact with the Participant, despite consistent, assertive engagement on the part of the Contracted Provider.
    - Outreach attempts should be varied (time of day, type of outreach, locations, contacting other providers), and documented.
- The Participant is incarcerated, and the expected sentence is for longer than 90 days. The Participant is assessed to have a level of need higher than that which can be reasonably addressed via the Program, and a more appropriate alternative (such as a move to a nursing home) can be accessed.

**Discharge Processes** – Contracted Providers will establish written policies and procedures for Program discharges that incorporate the criteria identified above.

- All Participants shall be informed of the criteria for Program discharge at the time of their enrollment in the Program.
- Contracted Providers will communicate planned or potential discharges with the CFCM as soon as possible.
- For Participants not engaging for a substantial time-period despite consistent and assertive efforts by the Contracted Provider, the Contracted Provider is required to provide a written notice warning the Participant of the impending termination at least 14 calendar days prior to the expected date of discharge. This notice should clearly outline expectations and offer multiple options for re-engagement.
- All Participants shall receive written notification of Program discharge from the Contracted Provider that 1) clearly states the reason(s) for their discharge from the Program and 2) includes appeal instructions adherent to the Provider's grievance and appeal policy.
- Participants shall be provided with written information with regards to local services and resources that may be useful to them upon Program discharge, including but not limited to the names and numbers of professional and natural resources and agencies that address specific needs such as SSTA, food banks, and housing resource centers.
- For Participants being discharged because they have met the goals and objectives identified in their Housing Support Plan, a collaborative and supportive planning process shall be initiated approximately six to eight weeks before the expected Program discharge date. Such discharge planning should highlight the

Participant's strengths, and any skill and relationship development achieved during the service period. The Participant should also be able to talk through steps they can take and resources they can access if they face challenges in the future. The Participant's landlord or property manager may be involved in such planning, as appropriate.

- All Participants will receive written notification of Medicaid Program disenrollment from the CFCM at OEO that 1) clearly states the reason(s) for their exit and 2) includes appeal instructions to the State of Vermont.
- Each termination from the program will result in a PSHA Medicaid benefit disenrollment start date effective on the first calendar day of the following month. Notification forms with a disenrollment effective date for the first of the month will be processed for the last date of the previous month (for example, a December 1 effective date will be processed for November 30).

## Staffing and Staff Qualifications

Contracted Providers are responsible for assembling a qualified team of staff members to ensure the delivery of high-quality services under the Program. Each position under the Program must be supported by a written job description that identifies the credentials and core competencies required for hire into the position, as well as the reporting relationship(s), and key responsibilities associated with the role. Staff supervision (individual, group and/or dyadic) should be provided on an at least bi-weekly basis for all Program staff members, and a formal performance review should be completed for all Program staff members no less than annually.

Requirements for Program team composition, staff qualifications, and staff training are as follows:

- **Direct Service Staff** – Contracted Provider staff members who provide direct services to Participants under the Program must meet the following requirements for education and experience:
  - Bachelor's or Associate's degree in a human/social services field or other relevant field of study, and/or;
  - At least one year of relevant experience and/or training in the coordination of supportive housing or in the coordination of independent living services in a social services setting.

  Direct service staff may include qualified peer support providers, recovery support specialists and/or other individuals with lived experience of homelessness, mental health or substance use conditions, and/or justice involvement. Staff members

with lived experience who provide direct services under the Program must meet the education and experience requirements outlined above.

Contracted Providers must maintain a direct service staff to Participant ratio of between 1:9 and 1:14 for the duration of the Program unless otherwise agreed upon with the PSHA program manager at OEO.

- **Staff Trainings** – Any staff member who provides direct services for Participants must participate in annual training. The following trainings are strongly recommended for all direct service staff members:

    - Housing First
    - Harm Reduction
    - Trauma-Informed Care
    - Person-Centered Care
    - Motivational Interviewing
    - Assertive Engagement
    - Racial Equity, class consciousness, working with LGBTQIA individuals
    - Overdose prevention
    - HIPAA (required per contract)

  Any staff member who will be an HMIS user under the Program must complete HMIS training and become a certified HMIS user within four weeks of hire or joining the Program.

  Contracted Providers are expected to ensure that direct service staff members are fully onboarded with regards to internal agency policies and procedures related to service delivery and documentation. Such policies and procedures might include but are not limited to those related to the following: safety during home and community visits, documenting service delivery and client interactions, maintaining case records, protecting client confidentiality, and participant rights, including the grievance process and the termination of services policy.

  Contracted Providers are also expected to ensure that direct service staff members complete additional trainings in relevant subject matter areas over the course of their work with the Program so that the services they provide for Participants are grounded in a robust and up-to-date knowledge base. Relevant subject matter areas might include but are not limited to; tenant's rights, culturally responsive practice, mental health first aid, intentional peer support, conversations about suicide, reasonable accommodation, service planning and coordination, services for individuals who are aging, and secondary traumatic stress.

OEO may at any time request that Contracted Providers present written job descriptions, staff credentials, and documentation that required trainings have been completed.

Lastly, it is recommended that Contracted Providers have a clinician on staff or contract to provide clinical case consultation for direct service staff members as indicated. Clinical case consultation is viewed as a best practice to support decision-making by direct service staff members, especially given the complex needs of most Participants who receive services through the Program. Staff members or contractors who provide clinical case consultation should have a higher-level clinical degree, including but not limited to LICSW, LCSW, or RN, and at least one year of clinical supervisory experience.

## Contracted Provider Policies and Procedures

Contracted Providers must have written policies and procedures in place that ensure the following:

- Maintenance of a complete, confidential case record for each Participant enrolled in the Program. Case records may take any format; however, they must comply with current case management documentation standards and must include the following: initial and updated Housing Search Plans and Housing Support and Crisis Plans; all completed Participant assessments; Participant contact notes; Participant progress notes, and case conference summaries, as appropriate. Note that the case record for each active Participant must clearly demonstrate that the minimum level of service delivery required for monthly Medicaid billing was met for each month that a Medicaid reimbursement request is submitted.

- A transparent and accessible Grievance Process, and a method for documenting that the Grievance Process was communicated to the Participants prior to Program enrollment that aligns with the Department of Vermont Health Access (DVHA) processes for appeals, fair hearings, and grievances..

- A clear statement of Participant Rights and Responsibilities, including but not limited to the above referenced Grievance Process, and a method for documenting that the Participants Rights were communicated to the Participant prior to enrollment in the Program. Potential grounds for discharge must be outlined here.

- A clear statement of grounds for Termination or Denial of Services policy specific to the Program.

- Compliance with the most current Federal and State laws pertaining to privacy and security of all Personal Health Information (PHI), including but to limited to with regards to case records. (Note that such policies and procedures must include a provision for sharing information with direct treatment providers and care management/care coordination staff at collaborating entities).

- Non-duplication of Program funding with other State and Federal funds.

- Other policies as outlined in the contract

OEO may at any time request that Contracted Providers present their written policies and procedures for ensuring the above.

# SECTION III: BILLING AND REIMBURSEMENT GUIDELINES

## Requirement to Enroll as a Vermont Medicaid Provider

In addition to entering into a contract with OEO to provide services under the Program, Contracted Providers must also enroll as a Vermont Medicaid provider in order to submit claims and receive reimbursement for eligible services. In accordance with Section 6401 of the Affordable Care Act of 2010 (ACA), all enrolled and newly enrolling providers will be subject to federal screening requirements.

Gainwell Technologies is the fiscal agent for the Vermont Medicaid Program and processes provider enrollment applications. Green Mountain Care (VT Medicaid) enrollment & revalidation instructions can be found at http://www.vtmedicaid.com/assets/provEnroll/GrnMtnCareEnrollInst.pdf

Codes required to enroll with Medicaid to provide PSHA services

- Provider Type: T47 (FAMILY SUPPORTIVE HOUSING)
- S55-Permanent Supportive Housing
- Taxonomy: 171M00000X - Case Manager/Care Coordinator

*See Attachment D – Medicaid Enrollment Guide*

## Reimbursement Rates and Minimum Levels of Service Delivery

*See Appendix E – PSHA Services and Community Transition Assistance Reimbursement Rates*

There are distinct reimbursement rates and processes for Pre-Tenancy Support Services and Tenancy Sustaining Services versus Community Transition Assistance, as described below. Note that Exhibit A provides a consolidated fee schedule for all services provided under the Program, including billing codes and reimbursement caps.

- **Pre-Tenancy Support Services and Tenancy Sustaining Services** – These services are reimbursed on a "Per Member Per Month" (PMPM) basis. PMPM means that Contracted Providers receive a monthly reimbursement at an established rate for each Participant for whom a claim is submitted, so long as they have provided the minimal level of service to each Participant in that month.

  The reimbursement rate for Pre-Tenancy Support Services and Tenancy Sustaining Services is $667.00 PMPM.

  The minimum level of service delivery that must be provided to a Participant in a given month order to claim reimbursement for services in that month is as follows:

  - Pre-Tenancy Support Services:
    - Two (2) in-person engagements with the Participant related to developing, implementing, or updating the Housing Plan(s) required under the Program.

  - Tenancy Sustaining Services:
    - Two (2) in-person engagements with the Participant related to developing, implementing, or updating the Housing Plan(s) required under the Program.

  <u>Note that Contracted Providers are expected to deliver services at the level of intensity needed to help the Participant achieve the goals identified in their person-centered CFCM Care Plan regardless of minimum standards</u>.

  Contracted Providers are expected to maintain records that document that the minimum level of service delivery was completed for each reimbursement claim they submit. Contracted Providers must be able to produce such records upon OEO request.

- **Community Transition Assistance –** This assistance is reimbursed on a cost basis up to the following caps:

| Assistance | Cap |
|---|---|
| Security deposit | Up to $2,000 One Time* |
| Move-in support, including essential household furniture | Up to $1,000<br>Lifetime cap |
| Essential utilities set-up | Total of $1500 **<br>• Utility deposits<br>• Payment to reinstate utilities<br>• Utility arrears<br>Lifetime cap |
| Pest Eradication ***<br><br>Other services TBD | • $3,000<br><br>Annual Cap |

*Housing/Security Deposits can be approved one additional time with documentation as to what conditions have changed to demonstrate why providing a second Security Deposit will lead to more successful permanence in housing.

**Utility costs are capped at a total of 6-months of arrears and prospective payments.

*** Costs for Pest Eradication for bedbugs will be approved if the Participant is responsible for the payment. Following Vermont tenant rights, it is the landlord's responsibility for extermination when the dwelling has two or more units infested with bedbugs simultaneously or the unit was infested prior to move in.

As noted in Section II, Community Transition Assistance must be clearly identified as reasonable and necessary in the Participant's individualized Housing Search Plan in order to be reimbursable. Additionally, Community Transition Assistance may be accessed only when the Participant is unable to cover the relevant expense using other resources. The Participant must be receiving Pre-Tenancy Support Services or Tenancy Sustaining Services to be eligible for Community Transition Assistance.

All requests for reimbursement of Community Transition Assistance must be accompanied by appropriate supporting documentation (e.g., invoices, receipts, etc.)

Returned security deposits must always go to the lessee on all occasions, despite who made the initial payment.

*See Appendix F – Community Transition Assistance Policies and Appendix G – Community Transition Application.*

## Prior Authorization/Re-Authorization

Prior Authorization to receive Program services must be on file for the Participant in order for the Contracted Provider to seek reimbursement for services provided to that Participant. Prior Authorization allows the Contracted Provider to bill for up to twelve (12) months of services as long as Medicaid enrollment is maintained. Additional Prior Authorizations may be approved for the Participant based on an annual re-assessment of their need for Program services.

The CFCM team is responsible for assessing Participant need and issuing Prior Authorization for Program services. Contracted Providers should contact their CFCM team representative if they have questions about the status of a Prior Authorization. In addition, Contracted Providers should also contact the CFCM team at least 30 days prior to the re-assessment/re-authorization to share updated case information related to the ongoing need for services.

## Claim Submission Format and Frequency

Contracted Providers have a choice of using either an electronic claim or paper claim submission format:

- Claims can be submitted on paper by completing the CMS 1500 Form for Medicaid Billing.

- Electronic claim filing facilities faster claim processing and payment. Contracted Providers can apply for a Transaction Services Account for electronic claims submission capabilities. The application and required forms can be found at http://www.vtmedicaid.com/#/hipaaTools.

Claims for Pre-Tenancy Support Services and Tenancy Sustaining Services may be submitted once per month for each Participant with an active Prior Authorization of

services on file, so long as the Contracted Provider has met the minimum service delivery requirements for the Participant in the relevant month.

Claims for Community Transition Assistance may be submitted on an as-needed basis up to the identified per Participant caps. These funds will be reimbursed to the Contracted Provider.

## Information Needed for Claim Submission

Contracted Providers will need to have the following information in order to submit a claim for reimbursement of Program services:

- **Diagnosis Code** – The diagnosis code describes the Participant's condition and the reason for services.

  Contracted Providers should utilize only a diagnosis code related to homelessness for all claims submitted under the Program. Diagnosis codes related to homelessness are outlined in the table below. If a Contracted Provider is uncertain as to the specific nature of the Participant's homelessness (for example, sheltered homelessness versus unsheltered homelessness), they may use the diagnosis code Z59.00 to submit the claim. (Please note that Z codes may be subject to change)

| Code | |
|---|---|
| **Z59.00** | Homelessness unspecified |
| **Z59.01** | Sheltered homelessness |
| **Z59.02** | Unsheltered homelessness |
| **Z59.1** | Inadequate housing (lack of heating/space, unsatisfactory surroundings) |
| **Z59.811** | Housing instability, housed, with risk of homelessness |
| **Z59.812** | Housing instability, housed, homelessness in past 12 months |
| **Z59.819** | Housing instability, housed unspecified |

- **Procedure Code** – The procedure code (also known as the CPT Code) identifies the service or good provided to the Participant for which the claim is being submitted.

  Contracted Providers should utilize the following procedure codes for claims submitted under the Program:

- Pre-Tenancy Support Services – **H0044 U1**
- Tenancy Sustaining Services – **H0044 U2**
- Community Transition Assistance
  - Security Deposit – **H0043 U4**
  - Move-in Support – **H0043 U1**
  - Essential Utilities – **H0043 U2**
  - Pest Eradication – **H0043 U3**

For the next full month of services after a Participant moves into housing, their Z code and procedure codes should be changed accordingly.

- **Claim Amount** – The claim amount identifies the dollar amount of the reimbursement for which the claim is being submitted.

  Contracted Providers should identify the dollar amount of claims submitted under the Program as follows:

  - Pre-Tenancy Support Services -- $667.00 per member per month for all claims
  - Tenancy Sustaining Services -- $667.00 per member per month for all claims
  - Community Transition Assistance– The actual dollar amount of the assistance for which the claim is being submitted not to exceed the caps identified above

- **Medicaid ID** – The Medicaid ID number identifies the Participant who received the service or good for which the claim is being submitted. The Medicaid ID should be included with the Participant information provided to the Contracted Provider upon Participant referral.

## Payment for Services

Payment for services is made by electronic funds transfer (EFT) only. Contracted Providers will set up EFT during the Medicaid provider enrollment process.

## Special Investigations Unit

Vermont Medicaid pays only for services that are actually provided and that are medically necessary. In filing a claim for reimbursement, the code(s) should be chosen that most accurately describes the service that was provided. It is a felony under

Vermont law 33VSA Sec. 141(d) knowingly to do, attempt, or aid and abet in any of the following when seeking for receiving reimbursement from Vermont Medicaid:

- Billing for services not rendered or more services than actually performed
- Providing and billing for unnecessary services
- Billing for a higher level of services than actually performed
- Charging higher rates for services to Vermont Medicaid than other providers
- Coding billing records to get more reimbursement
- Misrepresenting an unallowable service on a claim as another allowable service
- Falsely diagnosing so that Vermont Medicaid will pay more for services

For more information on overpayments and potential interest charges, visit the General Provider Manual, Section 6. https://vtmedicaid.com/#/manuals

Suspected fraud, waste or abuse should be reported to the DVHA Special Investigations Unit at https://dvha.vermont.gov/providers/special-investigations-unit, telephone 802.241.9210, or the Vermont Medicaid Fraud Control Unit of the Vermont's Attorney General's Office, telephone 802.828.5511.

## Performance Measures

In addition to billing and reporting required to process claims, Contracted Providers must submit a quarterly PSH Performance Measurement Report to OEO. Contracted Providers will report on the "PSHA Performance Measures"
*See Appendix H – Performance Measures and Reporting Schedule.*

In the event that a quarterly report indicates that a Contracted Provider's performance falls below the expectations outlined in Exhibit B, the Contracted Provider, in conjunction with the State Office of Economic Opportunity, may develop an Action Plan, Training and Technical Assistance Plan, or a Quality Improvement Plan, to be signed by both parties and submitted to the PSHA Program Manager within 30 days. Continued failure to meet the minimum requirement may result in loss of fees or cancellation of the contract. An ability to meet or exceed these performance goals will be considered for future funding.

## Appendix List

A – Sample Habitability Checklist

B – Housing Standards Guidance

C1 – Critical Incident Reporting Policy

C2 – Sample Critical Incident Report Form

D – Medicaid Enrollment Guide

E - PSHA Services and Community Transition Assistance Reimbursement Rates

F – Community Transition Assistance Policies

G – Community Transition Assistance Application

H – Performance Measures and Reporting Schedule