# Supported Housing/Enhanced Supported Housing

**Definitions:**

Psychiatric Rehabilitation services are defined by the Bureau of TennCare per the Contractor Risk Agreement (CRA). UnitedHealthcare Community Plan adheres to the definitions of Psychiatric Rehabilitation services (including supported housing) provided in the CRA and requires providers to adhere to these definitions as well. Copies of the CRA can be found at https://www.tn.gov/content/dam/tn/tenncare/documents/MCOStatewideContract.pdf \

**Description of Supported Housing (SH) services:** SH services are transitional services and refers to the psychosocial rehabilitation (PSR) services rendered at facilities that are staffed twenty-four (24) hours per day, seven (7) days a week with associated mental health staff supports for individuals who require treatment services and supports within a highly structured, safe, and secure setting. These wrap- around mental health services are for persons with serious and/or persistent mental illnesses (SPMI) and are intended to prepare individuals for more independent living in the community while providing an environment that fosters recovery and resiliency and allows individuals to live in community settings. Given this goal, every effort should be made to place individuals in facilities near their families and other support systems and in the community of their choice. SH does not include room and board payment.

**Description of Enhanced Supported Housing (ESH) services:** In addition to the description for SH services, members in ESH require care which exceeds the supports and intervention levels provided in standard SH. Behavioral health care needs may include mental health and/or substance abuse.
Generally, members in this level of care have co-existing physical health conditions that require a higher degree of staff oversight and/or intervention than would be standard for SH levels of care. This customarily includes additional 1:1 staffing accommodations for their medical co-morbidities and behavioral health conditions.

Providers will ensure that all SH/ESH providers, including subcontracted providers, are trained and supervised in accordance with the service standards established by the Tennessee Department of Mental Health and Substance Abuse Services.

Supported Housing services (both SH and ESH) are intended to be temporary and transitional in nature and must be designed to prepare individuals to live in an independent community setting. This is accomplished primarily using PSR services offered to members by SH/ESH providers at a level of 15 hours per week (members have no PSR benefit limits, but additional hours are to be utilized only when medically necessary). The 15 hours of PSR provided by the SH/ESH provider may not be billed separately from the SH/ESH service. The goal of SH/ESH, through the use of PSR services, is to assist the member in achieving recovery and resiliency objectives, and entails development of skill sets enabling members to become self-sufficient and self- directed in their life's pursuits. Areas of focus for PSR might include goals such as helping the member develop the skills and experience needed to independently access transportation services (e.g. - to take public or TennCare transportation to their clinical appointments), to enhance their

ability to engage in their agreed upon clinical treatment goals (e.g. - take their medication as prescribed, or doing so without supervision), to manage their finances as independently as possible, etc.

MCO funds are not utilized to pay for room and board but are intended to fund mental health supports and PSR services. The 15 hours per week of PSR services the SH/ESH provider is required to offer the member ideally will occur on site at the SH/ESH location. If PSR services are provided off site, the SH/ESH provider is accountable for these services and is expected to monitor and ensure the services are medically necessary and the member is making progress towards PSR goals identified by the member, in collaboration with the contracted PSR provider.

SH/ESH providers are expected to coordinate all necessary physical and behavioral healthcare needs that members may have, including assistance with positive medication participation.

**Program Service Expectations for SH and ESH:**
Prior to admission, initial case review for medical necessity determination will be completed with UnitedHealthcare Community Plan UM staff using forms developed for SH/ESH services.

1. Within thirty (30) days of admission to SH/ESH service, the member will work with SH/ESH staff to develop a SH/ESH specific care plan that is updated every 90 days. The care plan will include the following:
   a. Specific, targeted care needs being addressed that relate to the mental health, physical health, and/or substance abuse condition(s) that warrant SH/ESH, and the frequency of targeted issues. For example, targeted care needs might focus on positive medication participation, identification and removal of barriers to regular attendance at scheduled clinical appointments or other community resources (including identification and removal of barriers to accessing transportation services to scheduled appointments or community resources), identification and removal of barriers to gainful employment, etc.;
   b. Specific, measureable goals that are time-limited and clearly related to the condition and/or symptoms that led to admission;
   c. Specific, concrete interventions noting the frequency for intervention(s) being provided, and specific time frames for the delivery of these interventions;
   d. Specific projected date of discharge to a less intensive setting.
2. Within thirty (30) days of admission to the SH/ESH service, the member will work with SH/ESH staff to develop a discharge plan that is congruent with and supportive of the principles of recovery and/or resiliency. The discharge plan will include the following:
   a. Projected date of discharge to a less intensive setting;
   b. Concrete and detailed housing transition plan to include type of placement, specific locations under consideration, and steps member will take to make the final decision (visiting the housing option, transportation to the site, meeting staff);
   c. Specific anticipated aftercare services and potential providers (mental health, physical health, specialty care, and/or substance abuse, community-based services, etc.)
   d. Within 30 days of admission to SH/ESH, the provider will assist the member in obtaining a physical exam to address routine screenings and any specialty care that may be necessary (neurology, endocrinology, etc.). The exception would be for members who have evidence in their SH/ESH record indicating such screening and exams occurred within the 60 days prior to admission to SH/ESH.

3. SH/ESH providers are expected to coordinate and collaborate with **all** other treating providers to optimize treatment benefits and continuity of care regarding all ongoing care/services the member is participating in, including follow-up services.
4. Members in SH/ESH **must not** be required to leave their residence during the day/evening as a condition of admittance or continued stay. As part of the member's treatment plan, the member should be permitted to leave the SH/ESH site independently to engage in unsupervised community activities in order to practice using daily recovery and living skills.
5. Fifteen (15) hours of required weekly mental health and/or psychosocial rehabilitation is expected to address the member's individual needs and build on his/her strengths.
    a. All contacts/activities shall be documented in the member's clinical record.
    b. The fifteen (15) hours should not be billed separate from a SH/ESH claim and should be included in the per diem for any SH/ESH claim.
    c. SH/ESH providers are expected to offer the required 15 hrs. per week ideally onsite.
    d. When this SH/ESH services are provided from a subcontractor, the contractor shall be held accountable for the oversight of these services.
6. In the vast majority of cases, 15 hours of psychosocial rehabilitation services per week is sufficient to meet the members care needs (e.g. - members do not routinely need more psychosocial rehabilitative services per week to accomplish their identified treatment goals). However, mental health and/or PSR services beyond the fifteen (15) hours provided to each member at the SH/ESH site can be offered and billed separately from those provided within SH/ESH service, if the services meet the threshold for medical necessity. Psychiatric Rehabilitation services such as IMR or Supported Employment can also be provided, if medically necessary. All psychosocial rehabilitation services must be provided according to the member's treatment plan and give consideration to the member's choice of provider(s) and preferences.
7. SH/ESH services are available twenty-four (24) hours, seven days per week and delivered by qualified staff.
8. All concurrent reviews and requests for additional services must be completed 14 days prior to the end of the current authorization period.

**SH/ESH Admission Criteria (all must be met):**

1. The member's care needs meet the definition of the TennCare Medical Necessity Criteria per TennCare Rule 1200-13-16-.05.
2. SH/ESH services must be ordered by an independently licensed behavioral health clinician (MD, MSRN, APRN, Licensed Psychologist, LCSW, LPC, LMFT, or LSPE) who has assessed the member within 30 days of the initial request for service.
3. The member is classified as a TennCare Priority Enrollee or is diagnosed with a primary mental health diagnosis that would qualify for this rating. UHCCP may request all assessment information related to such diagnosis.
4. The member has been educated regarding SH/ESH services and expresses an interest and willingness to participate in SH/ESH services.
5. The member is 18 years or older and has the means to pay room and board for the group home living, or the provider has agreed to provide room and board at no cost.
6. While the member does not require total care with daily living skills, the member requires a level of daily support that cannot be provided in a less intensive level of care.

7. The member is functioning at a cognitive level that allows him/her to make gains and benefit from rehabilitative services provided in SH/ESH venues. Members with cognitive impairment from any condition (e.g., TBI, intellectual or developmental disability, dementia, schizophrenia with prominent negative symptoms, etc.) may not be appropriate for SH/ESH services if their cognitive impairment precludes them from benefitting from rehabilitative services. These members may be more appropriately served in Supportive Community Living (SCL).
8. The member's physical health status will not impair or impede his/her ability to make gains and benefit from PSR services provided in SH/ESH services. Members who have sufficient physical health issues that qualify them via Pre-Admission Evaluation (PAE) or Pre-Admission Screening and Review (PASR) for a higher level of care such as nursing home care are not appropriate for SH/ESH.
9. The member is either stepping down from a higher level service or is at risk of a higher level service such as, but not limited to, psychiatric hospitalization, adult mental health residential treatment facility, and/or incarceration due to his/her mental illness. SH/ESH is not solely used to provide a solution for homelessness or incarceration.
10. The provider is able to identify the targeted symptoms and behaviors that will be addressed with SH/ESH. The goals for the target symptoms and behaviors, and the interventions that will be provided through SH/ESH will be measureable and time-limited, and will assist the member toward independent living within the community.
11. ESH members require care exceeding the supports and intervention levels provided in standard SH. Behavioral health care needs may include mental health and/or substance abuse. Generally, members in this level of care have co-existing physical health conditions (cancer, PIC lines or ports, etc.,) that require a higher degree of staff oversight and/or intervention than what would be standard for SH levels of care. This customarily includes nursing oversight and/or additional individual supports. These members typically require assistance with medication administration, wound care, and/or other accommodations for their medical co-morbidities and behavioral health conditions. Members must be able to ambulate or complete their own transfers.
12. Members in SH and ESH must be actively engaged and/or stepping down from service and/or recovery services (including therapy and medication management)

**Exclusion from SH and ESH:** The primary problem cannot be social, economic or of a physical nature without a concurrent major psychiatric condition.

**SH/ESH Continued Stay Criteria (all must be met):**

1. The member continues to meet the Admission Criteria for SH/ESH.
2. SH/ESH is the least intensive service and setting to meet the member's needs.
3. The provider is actively providing services to the member that allows him/her to acquire the skills necessary to live independently in a setting of the members choosing upon discharge from SH services.
4. With each request for concurrent review, documentation is required that demonstrates the ongoing treatment and progress as it relates to the initial reason for admission to SH/ESH, to include updated clinical information, service/treatment plans, and progress notes.
    a. Current SH/ESH specific care plan must include:
        i. Evidence the member has participated in the development and revisions of the care plan;
        ii. Specific issues being addressed and frequency of targeted interventions;

iii. Specific, realistic, concrete and measureable goals with timeframes for achievement;
iv. Specific mental health, physical health, substance abuse needs, and any other social determinants of health.

b. SH/ESH discharge plan must include:
   i. Evidence the member and/or conservator participated in the development of the discharge plan;
   ii. Specific projected date of discharge to a less intensive setting; iii. Concrete and detailed housing transition plan;
   iv. Specific anticipated aftercare services (mental health, physical health, and/or substance abuse).

5. The member is making measurable progress in developing the specific skills identified by the provider to move to the less intensive setting.
6. ESH members require care exceeding the supports and intervention levels provided in standard SH. Behavioral health care needs may include mental health and/or substance abuse. Generally, members in this level of care have co-existing physical health conditions that require a higher degree of staff oversight and/or intervention than what would be standard for SH levels of care. This customarily includes nursing oversight and/or additional individual supports. These members typically require assistance with medication administration and accommodations for their medical co-morbidities and behavioral health conditions.

**SH/ESH Discharge Criteria:**

1. One or more of the Continued Stay Criteria are no longer met.
2. There is lack of measurable progress and no identified clinical intervention that will likely change the lack of measurable progress.
3. There is evidence that time-limited and measurable goals identified within the service plan have been sufficiently met to continue addressing any ongoing needs at a lower level of care/service intensity. For example, a member who continues to struggle with budgeting has a payee to assist with financial management and supports, while the member receives peer coaching from a Certified Peer Specialist.
4. The member’s overall functioning level has increased to a level that the member can remain safe in the community in an alternate setting.
5. The symptoms and behaviors identified as meeting medical necessity criteria for SH/ESH services have sufficiently decreased and functioning has improved to a point that the member can be moved to a less intensive level of care. This may include absence of acute psychiatric hospitalization in the last three months.
6. The member is identified as needing a higher level of care.
7. The member refuses to participate or engage in services/declines services.

**Exceptions:**

All exceptions to the Supported Housing/Enhanced Supported Housing criteria or service expectations must be approved in writing by UnitedHealthcare Community Plan.