MCO Guidance Packet

NJ FamilyCare Housing Supports program

NJ Department of Human Services

Prepared by the NJ Division of Medical Assistance and Health Services (DMAHS)

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Housing Supports Program

MCO Guidance

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1. Program Overview

A. Background

With the Centers for Medicare and Medicaid (CMS) approval of New Jersey's Section 1115 Waiver Demonstration in April 2023, the Division of Medical Assistance and Health Services (DMAHS) obtained authorization to develop a Housing Supports program. The Housing Supports program is a set of housing services created to ensure Medicaid/NJ FamilyCare members can live in safe, healthy, and affordable homes. The program will provide much needed support to some of Medicaid's most vulnerable members including those with complex medical or behavioral health needs who are also homeless or at-risk of homelessness.

The Housing Supports program consists of four services:

- Pre-tenancy Services (case management)
- Tenancy Sustaining Services (case management)
- Move-in Supports
- Residential Modifications and Remediation Services

To be considered eligible for the Housing Supports program an individual must meet each of the following:

1) Enrolled with an MCO
2) Meet at least one of the social-risk criteria (as defined in (4.A)
3) Meet at least one of the clinical-risk criteria (as defined in (4.B)

B. Purpose and Principles

Housing is a driver of disparate health and quality of life outcomes among racial and ethnic groups, individuals with disabilities, and other vulnerable populations. Housing is also one of the primary social determinants of health, and research has shown that lack of or inadequate housing is a critical barrier to wellness and raises health care costs[1]. As such, in 2015, CMS began allowing states to add housing services to their Medicaid programs[2]. Once DMAHS's 1115 waiver renewal was up for submission, DMAHS sought an opportunity to leverage this new CMS flexibility and added Housing Supports to the 1115 waiver.

For many Medicaid beneficiaries, lack of affordable, appropriate housing is a critical barrier to wellness. Lack of stable housing may lead to unnecessary hospitalization, institutionalization, or other avoidable instances of high-cost care, negative clinical outcomes, worsening of chronic conditions, and inability to achieve key life goals.

Accordingly, DMAHS has two primary goals for the Housing Supports program:

- Provide access to Housing Supports services that help homeless and other housing insecure members find homes and remain in their homes, thereby improving health outcomes.

[1] Taylor, Lauren A., Housing and Health: an Overview of the Literature; DeLia D, et al. Effects of Permanent Supportive Housing on Health Care Utilization and Spending Among New Jersey Medicaid/NJ FamilyCare Enrollees Experiencing Homelessness. Med Care. 2021

[2] Wachino, Vikki., Coverage of Housing-Related Activities and Services for Individuals with Disabilities. Centers for Medicare and Medicaid Services. 2015.

- Drive greater connection of the housing and health care ecosystems by integrating member coordination of care into Managed Care Organizations (MCOs) and Medicaid funding into the housing ecosystem.
    - MCOs will better deliver whole-person care for vulnerable members.
    - Medicaid funding will augment, not supplant, existing funding and programs for homeless and other housing insecure populations.

C. Guidance Structure

This guidance document is for MCOs and is designed to clarify and elaborate the standards included in the MCO contract. As such, the guidance is structured by topics that mirror the MCO contract.

Initially, this document will serve as a roadmap for MCOs to support the readiness process. Once the program is fully implemented, this document will serve as the central location for the program standards.

DMAHS reserves the right to update this document as necessary. The update history is noted in **Section 17.**

D. Roles and Responsibilities

MCOs

The MCO is responsible for administrative functions, including:

- Contracting and credentialing Housing Supports providers to ensure that there is a sufficient network of providers to address member needs.
- Paying valid claims to Housing Supports providers within required timeframes.
- Reporting encounter data to DMAHS.
- Making service authorization determinations, consistent with DMAHS guidance.
- Making timely referrals, monitoring member outcomes, and providing care management via care managers and Housing Specialists.
- Coordinating 'warm-handoffs' or transitions to other housing or social services, if the member is not eligible or no longer eligible for Housing Supports.
- Arranging for Move-in Supports, as appropriate.
- Reporting on required metrics to DMAHS.

Community based organizations ("Housing Supports providers")

Housing Supports providers are responsible for delivering services; more specifically including:

- Delivering Housing Supports services (i.e., Pre-tenancy Services, Tenancy Sustaining Services, Move-in Supports, or Residential Modifications and Remediation Services) consistent with requirements in the following guidance and services dictionary (e.g., documenting touchpoints for Pre-tenancy and Tenancy Sustaining Services in New Jersey's Homeless Management Information System [HMIS]).
- Enrolling with DMAHS as a provider.
- Contracting and credentialing with MCOs.
- Billing MCOs for services delivered.
- Communicating with MCO care management, Housing Specialist, and utilization management staff to submit authorization requests and share updates on changing member needs (e.g., member is housed, member's level of need changes).

DMAHS

DMAHS is responsible for:

- Overall program design, including setting provider rates for program services.
- Providing overall oversight, monitoring and evaluation of the program.
- Ensuring standards and guidance are enforced according to the contractual obligations.

2. Definitions

The following terms shall have the meaning stated:

- **Business Day** – Any weekday, excluding Saturdays, Sundays, NJ State or Federal legal holidays, and State-mandated furlough days
- **Household** – An individual or group of individuals who seek to live in a home together, including related and non-related family. For the purposes of the Housing Supports program and this guidance, a member is not part of a household with those they currently live with if the member no longer seeks to live with the other individuals in the house (e.g., domestic violence victim; individual couch surfing seeking stable housing).
- **Housing Services Manager** – MCO housing services manager staff overseeing MCO Housing Specialists.
- **Housing Specialist** – MCO staff working 1:1 with members in Housing Supports program ensuring member is referred to relevant Housing Supports providers and that services are being delivered (see Housing Specialist responsibilities in **Section 9.B.**)
- **Housing Stabilization Plan** – Document that includes the member's goals and action plan to achieve stable housing. The plan is created with a member and their Tenancy Provider's housing case manager. The Tenancy Provider then submits the housing stabilization plan to the MCO to request authorization to continue Tenancy Services. See **Section 16**
- **Housing Supports** – includes Pre-tenancy Services, Tenancy Sustaining Services, Residential Modifications and Remediation Services, and Move-in Supports. See Housing Supports Services Dictionary (Appendix B.9.4) for detailed service descriptions list.
- **Initial Assessment Tool** – Tool used to assess member's eligibility for Housing Supports and request service authorization from the MCO. See **Section 16**
- **Level of Need Assessment** – To be used by Tenancy Provider to assess member eligibility for Tenancy Services and level of need (i.e., higher or lower level of need). The Level of Need Assessment is used to request authorization to continue Tenancy Services. See **Section 16**
- **Tenancy Provider** – Providers of Pre-tenancy and Tenancy Sustaining Services.
- **Tenancy Services** – Includes Pre-tenancy and Tenancy Sustaining Services.

3. Covered Services

A. Overview of Covered Services

Housing Supports includes 4 main services:

- Pre-tenancy Services (case management)
- Tenancy Sustaining Services (case management)
- Move-in Supports
- Residential Modifications and Remediation Services

For the full detailed description of the services listed below, please see the Housing Supports Services Dictionary (See **Section 15.A).**

Pre-tenancy Services	Tenancy Sustaining Services	Move-in Supports	Modifications and Remediation
• Develop an individualized housing support plan to help member achieve their goals • Assist with the housing search and application process • Provide connections to resources aiding with housing costs and other expenses	• Develop an individualized housing support plan to help member achieve their goals • Assist with lease renewals and housing certification process • Connect the member to financial resources and social services, including linking members to education, employment and legal services • Assist in addressing circumstances and/or behaviors that may jeopardize housing • Assist in resolving disputes with landlords	• Pay for the set-up of the new housing unit, to address needs identified in the person-centered care plan • Pay for the move and supporting the details of the move	• Provide remediation services, including air filtration devices, asthma remediation • Modify home environment (e.g., ramps, handrails, grab bars) • Provide medically necessary heating and cooling services

Exhibit 1. Overview of Covered Services.

4. Covered Populations

- **<u>Overview of Covered Populations</u>**

To be considered eligible for the Housing Supports program an individual must meet each of the following:

1) Enrolled with an MCO
2) Meet at least one of the social-risk criteria (as defined in 4.A)
3) Meet at least one of the clinical-risk criteria (as defined in 4.B)

MCOs must accept attestations of social and clinical eligibility criteria by the submitter of the assessment. That is, third party documentation of the member's clinical risk criteria and/or social risk criteria is not required to complete the form or obtain approval from the MCO.

A. An individual meets the social-risk criteria requirement if they meet any of the (HUD-aligned) definitions outlined in subsections <u>a-e</u> below:
    a. Homeless

i. An individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning:
    1. An individual or family with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, camping ground, etc.;
    2. An individual or family living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels or motels paid for by charitable organizations or by federal, state, or local government programs for low-income individuals); or
    3. An individual who is exiting an institution where they resided for 90 days or less and who also resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.

ii. An individual or family who will imminently lose their primary nighttime residence, provided that:
    1. The primary nighttime residence will be lost within 14 days of the date of application for homeless assistance;
    2. No subsequent residence has been identified; and
    3. The individual or family lacks the resources or support networks, e.g., family, friends, faith-based or other social networks needed to obtain other permanent housing;

iii. Unaccompanied youth under 25 years of age, or families with children and youth, who do not otherwise qualify as homeless under this definition, but who:
    1. Are defined as homeless under section 387 of the Runaway and Homeless Youth Act (42 U.S.C. 5732a), section 637 of the Head Start Act (42 U.S.C. 9832), section 41403 of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2), section 330(h) of the Public Health Service Act (42 U.S.C. 254b(h)), section 3 of the Food and Nutrition Act of 2008 (7 U.S.C. 2012), section 17(b) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)), or section 725 of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a);
    2. Have not had a lease, ownership interest, or occupancy agreement in permanent housing at any time during the 60 days immediately preceding the date of application for homeless assistance;
    3. Have experienced persistent instability as measured by two moves or more during the 60-day period immediately preceding the date of applying for homeless assistance; and
    4. Can be expected to continue in such status for an extended period of time because of chronic disabilities, chronic physical health or mental health conditions, substance addiction, histories of domestic violence or childhood abuse (including neglect), the presence of a child or youth with a disability, or two or more barriers to employment, which include the lack of a high school degree or General Education Development (GED), illiteracy, low English proficiency, a history of incarceration or detention for criminal activity, and a history of unstable employment; or

iv. Any individual or family who:

1. Is fleeing, or is attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the individual or a family member, including a child, that has either taken place within the individual's or family's primary nighttime residence or has made the individual or family afraid to return to their primary nighttime residence;
2. Has no other residence; and
3. Lacks the resources or support networks, e.g., family, friends, faith-based or other social networks, to obtain other permanent housing.

b. At-risk of homelessness

i. An individual or family who meets one of the following conditions:
   1. Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;
   2. Is living in the home of another because of economic hardship;
   3. Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance;
   4. Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;
   5. Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;
   6. Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or
   7. Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan (Note: DMAHS finds grounds to categorize individuals living in physically unsafe homes as qualifying as at-risk of homelessness because the Department of Community Affairs (DCA) consolidated plan for New Jersey includes “individuals living in physically unsafe home”); or

ii. A child or youth who does not qualify as “homeless” under this section, but qualifies as “homeless” under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or

iii. A child or youth who does not qualify as “homeless” under this section, but qualifies as “homeless” under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him.

c. **Individuals at risk of institutionalization who require a new housing arrangement to remain in the community**
    i. Qualifying institutions include: hospitals, mental health residential treatment facilities, substance use disorder treatment facilities, and long-term care facilities
d. **Transitioning from an institution to the community**
    i. This includes beneficiaries who could potentially transition from an institution to the community but are unable due to insufficient placement options.
    ii. Qualifying institutions include: hospitals, mental health residential treatment facilities, substance use disorder treatment facilities, and long-term care facilities.
e. **Individuals released from correctional facilities**
    i. Includes beneficiaries released from incarceration within the past 12 months.
    ii. Qualifying institutions include: state and federal prisons, local correctional facilities, and juvenile detention facilities.

B. An individual meets the clinical-risk criteria requirement if they meet any of definitions outlined in subsections a-h below:
    a. **Chronic health condition**
        i. One or more chronic conditions consistent with those identified in Social Security Act section1945(h)(2). Examples of conditions can include: diabetes, BMI over 25, cardiovascular disease, respiratory disease, HIV/AIDS diagnosis, hypertension, physical disability (e.g., amputation, visual impairment), cancer, hyperlipidemia, chronic obstructive pulmonary diseases, chronic kidney disease.
    b. **Mental health condition**
        i. An individual with at least one serious mental health illness, consistent with conditions included in the definition in N.J.A.C. 10:37B and/or at least two concurrent mental health conditions that require support and are impacting the ability to maintain a stable housing situation. Applicable mental health conditions include but are not limited to: Bipolar Disorder; Borderline Personality Disorder; Depression; Dissociative Disorders; Eating Disorders; Obsessive-compulsive Disorder; Posttraumatic Stress Disorder; Psychosis Schizoaffective Disorder; and Schizophrenia.
    c. **Substance misuse**
        i. An individual with a substance use disorder who is in need of substance use treatment.
    d. **Pregnancy**
        i. An individual who is currently pregnant
        ii. An individual who is up to 12 months after the end of pregnancy.
    e. **Complex medical health condition caused by an intellectual or development disability**
        i. Qualifying physical, neurological, or behavioral, condition that directly impacts the ability to maintain a health and stable lifestyle.
    f. **Individuals experience intimate partner violence, domestic violence, and/or victims of human trafficking**
        i. An individual who is experiencing or has experienced intimate partner violence (IPV), domestic violence, or human trafficking.
    g. **Assistance with activities of daily living (ADLs) and instrumental ADLs (IADLs). Individual assessed to have a need for assistance with:**

i. 1 or more activity of daily living (ADL), or
ii. 3 or more instrumental activities of daily living (IADLs) and has a behavioral health condition or cognitive impairment (e.g., impairment to decision making or memory).

h. Repeated emergency department use or hospital admissions

i. An individual with repeated use of emergency department care (defined as two or more visits in the past 6 months or four or more visits in the past 12 months).

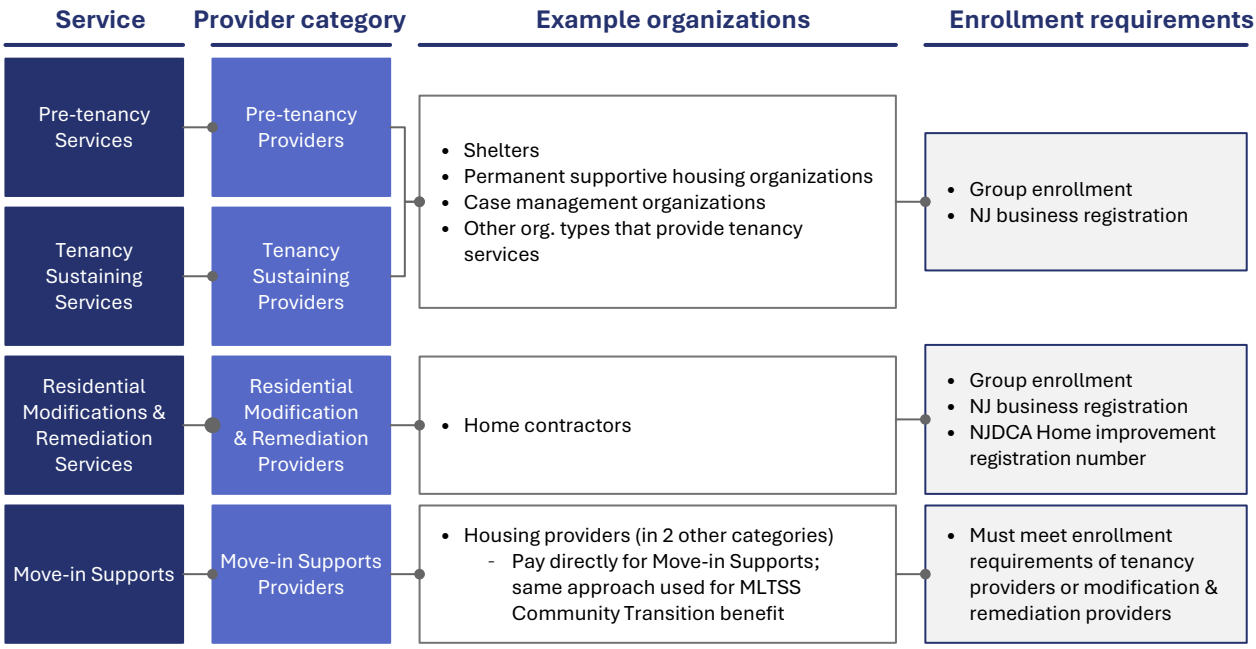
- **Unaccompanied Children**

Unaccompanied children (under 18 years old) are not appropriate for Housing Supports. The Housing Supports provider should call the NJ Child Abuse Hotline (1-877-652-2873; https://www.nj.gov/dcf/reporting/hotline/) to report the incidence and seek further guidance.

5. Provider Enrollment, Credentialing and Contracting

A. Overview of Provider Types and Qualifications

4 housing provider categories based on the 4 housing services



1. Note: Move-in Supports include paying for security deposits and moving costs. Tenancy Services providers, Residential Modifications & Remediation providers, and MCOs are well-positioned to directly arrange for these kinds of wide-ranging costs. As a result, DMAHS is not creating another distinct set of provider qualifications for Move-in Supports, but instead allows MCOs and other Housing Supports providers to deliver these services

Exhibit 2. Provider categories based upon type of housing service offered. Provider categories are not mutually exclusive (i.e., providers may provide both Pre-Tenancy and Tenancy Sustaining Services)

The Housing Supports program includes 4 provider categories based on the 4 housing services (Exhibit 2). Pre-tenancy Services are delivered by Pre-tenancy Providers. Tenancy Sustaining Services are delivered by Tenancy Sustaining Providers. Residential Modifications and Remediation Services are delivered by Home Modifications and Remediation Providers. Move-in Supports can be arranged by

Move-in Supports Providers or MCOs. Move-in Supports Providers may also be any of the abovementioned other 3 provider categories (or MCOs themselves).

Housing Supports are MCO-covered services – meaning these services are paid for and authorized by MCOs; they are not paid for FFS. To become an in-network Housing Supports provider with an MCO, an organization must complete the following steps:

i. **Obtain an NPI number**
   - Organizations can apply via <nppes.cms.hhs.gov>.
   - Organizations should apply for a Type 2 NPI
   - Taxonomy codes:
     i. 251B00000X (Case Management): Pre-tenancy and Tenancy Sustaining Services
     ii. 171W00000X (Contractor): Residential Modifications and Remediation Services

ii. **Enroll with Medicaid/NJ FamilyCare** via the Housing Supports Group Provider application available on NJMMIS.com.
   - Enrollment is at the organizational level only; individual housing case managers are not required to enroll individually.

iii. **Credential and contract with a managed care organization**
   - See **Sections 5.B-5.D** for additional detail on this process

B. Credentialing Forms

MCOs must credential Tenancy providers using the "Housing Supports Provider Credentialing Application Form for Pre-tenancy and Tenancy Sustaining Services." See **here** for the Credentialing Application Form.

MCOs must use their existing New Jersey Medicaid Non–Traditional Provider Application to credential Residential Modifications and Remediation Services providers.

Move-in supports providers may be credentialed as either Tenancy Providers or Residential Modifications and Remediation Providers, whichever is more appropriate.

C. Credentialing Application

MCOs must contract and credential housing support providers as organizations. Individual housing case managers and individual contractors are not required to credential with the MCOs individually or to be included in a roster.

DMAHS has shared additional guidance with MCOs on how to evaluate credentialing applications for Tenancy Providers.

During the credentialing process, MCOs must verify that the provider is Medicaid enrolled, with the following provider specialty code(s) associated with the service(s) that they intend to deliver (and be credentialed for):

- Pre-tenancy Supports Services Provider: 801
- Tenancy Sustaining Services Provider: 802
- Residential Modifications and Remediation Services Provider: 803
- Move-in Supports Provider: 804

Providers should be credentialed for the service that they are providing. Specifically, a provider offering both Tenancy Services and Residential Modifications and Remediation Services needs to be credentialed as both in order deliver and be paid for the service they are credentialed for. These may not apply if the MCO has an established Single Case Agreement with the provider.

Providers already credentialed for a non-housing service (e.g., FQHCs) must be credentialed for Housing Supports as outlined in **Section 5.B.** If the provider is already credentialed for MLTSS modifications, then it is up to MCO discretion to waive the formal credentialing process for Housing Supports Residential Modifications and Remediation Services.

D. Other Requirements to Join MCO Networks

Housing Supports providers must abide by background check policies. These policies may occur outside of the credentialing process and may require fingerprint-based background checks. Consistent with the current approach for MLTSS non-traditional providers, MCOs may meet their requirements to validate that providers have met their background check requirements by accepting an attestation that Housing Supports providers have completed criminal background checks for the authorized representatives of the organizations and member-facing employees.

6. Network Adequacy and Access

A. Overview of Network Adequacy and Access

MCOs must contract with any willing provider for the Housing Supports program that meets all requirements to participate through January 1, 2026. See appendix for provider specification requirements in the Housing Supports Services Dictionary. (For the purposes of the Housing Supports program, a “qualified” provider in the context of a network adequacy standard, shall mean a provider that meets all of the requirements to participate in the program.)

DMAHS reserves the right to define additional network adequacy requirements in the future.

7. Service Authorization

A. Overview of Service Authorization

Tenancy Services | High-level member journey

Exhibit 3. High-level member journey for Pre-tenancy and Tenancy Sustaining Services.

Tenancy Services: authorization process | Providers assess level of need, billing accordingly; MCOs conduct oversight

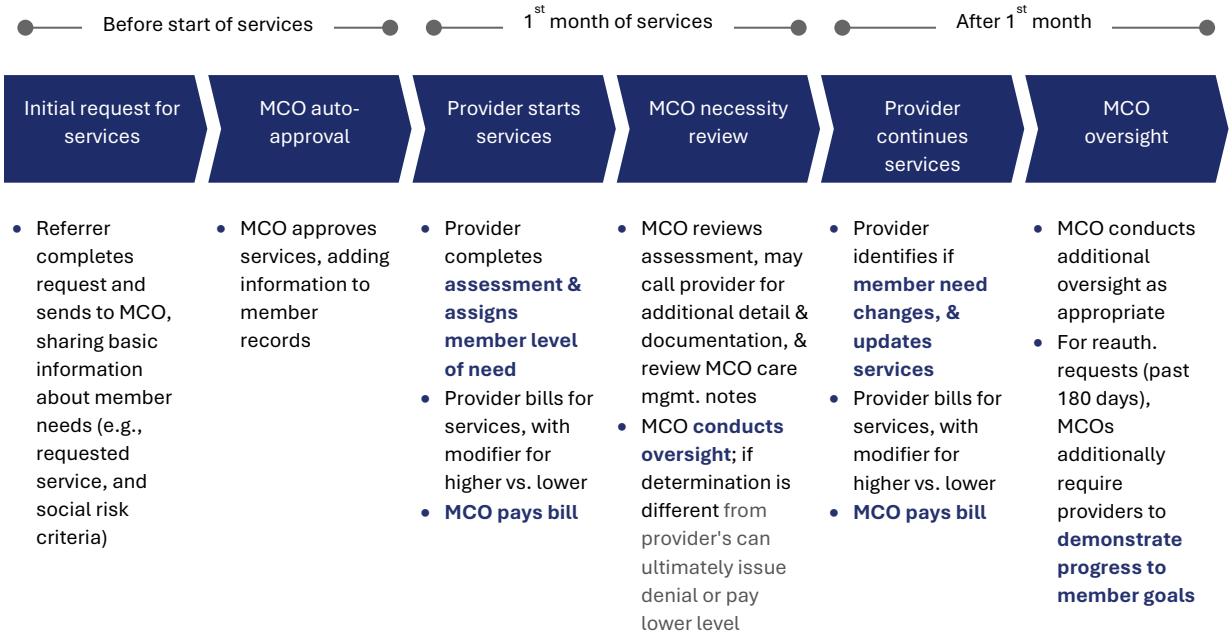


Exhibit 4. Authorization process for Pre-tenancy and Tenancy Sustaining Services.

The Housing Supports program member journey flows from identification of need to assessment of member eligibility, to service authorization, to an optional care management step, to delivery of services.

The authorization process depicted above is for Pre-tenancy and Tenancy Sustaining Services. Housing Supports Modification and Remediation and Move-in Supports are aligned to existing MLTSS practices; see **Section 7.F** below for more details.

B. Proactive Identification

MCOs should refer members to Housing Supports services based on proactively identified need, including but not limited to care manager identification or systems data (e.g., claims) that indicates a member is experiencing homelessness or is at risk of homelessness.

C. Duplication of Services

The Housing Supports program seeks to avoid duplicating other state and federal services and to connect members to the most appropriate resources to meet their needs. As such, the Housing Supports program seeks to supplement, not supplant other government-funded housing services.

MCOs must check for duplicate **Medicaid** housing services. Duplicate Medicaid housing services are defined as:

- For Pre-tenancy and Tenancy Sustaining Services:
  - A member or individuals in the same household are authorized for more than 1 Tenancy Provider at a time.
  - A member is authorized for Tenancy Services and Community Supports Services (CSS)[3] and Integrated Case Management Services (ICMS) at the same time[4].
- For Move-in Supports:
  - A member or individuals in the same household exceed the lifetime cap for Move-in Supports, including if a member changes MCOs, and including spending on MLTSS Community Transition Services.
  - A member is simultaneously authorized for Move-in Supports and CSS or ICMS, or if the member is currently enrolled in MLTSS.
- For Residential Modifications and Remediation Services:
  - A member or individuals in the same household exceed the lifetime cap for Residential Modifications and Remediation Services, including if a member changes MCOs, and including spending on MLTSS Residential Modifications and Remediation Services.

[3] Community Support Services (CSS) consist of mental health rehabilitation services and supports necessary to assist consumers in achieving the goals identified in their individualized rehabilitation plans. These include: achieving and maintaining valued life roles in the social, employment, educational and/or housing domains, restoring a consumer's level of functioning to that which allows community integration, and remaining in an independent living setting of his/her choosing.

[4] MCOs can check CSS by looking at the respective special program codes (https://www.njmmis.com/downloadDocuments/SpecialProgramCodes.pdf). Understanding that ICMS does not have a special program code but is still considered a duplicative service, MCOs are not required to check for ICMS through special program codes when authorizing services but should deny authorization if, from other sources such as the member care plan, they believe that the member is receiving ICMS.

- A member is simultaneously authorized for Residential Modifications and Remediations Services and currently enrolled in MLTSS.
- A member who participated in or is receiving services through Division of Development Disabilities (DDD) Community Care Program or Supports Program similar to Housing Supports Residential Modifications services (note: this limitation does not apply to Residential Remediation Services).

MCOs should also follow the guidelines below for duplication:

- Defining a household to check for duplication
  - MCOs should check household members listed on the member's 'Housing Supports Initial Assessment Tool' (for first 30 days, if for Tenancy Services) and the 'Level of Need Assessment' (for reauthorization, if for Tenancy Services).
  - MCOs can use utilize their internal systems data (e.g., Medicaid ID, mailing address) and HMIS data to validate a member's household; however, may not require additional documentation or verification from the member. If MCOs identify a different household than reported by authorization documents, then MCOs may investigate by clarifying with the provider. There are valid situations in which the defined household may differ from MCOs' data (e.g., situations of domestic violence).
- Identifying duplication specific to current and/or previous Housing Supports service utilization
  - For Tenancy Services: MCOs should check if other individuals in the same household are currently authorized for a Tenancy Service
  - For Residential Modification and Remediation Services or Move-in Supports: MCOs should check if authorized members exceed the cap when added to spending currently or previously authorized for other individuals in the same household.

MCOs must not deny services if the member is eligible for or receiving other non-Medicaid/NJ FamilyCare housing services. These other non-Medicaid/NJ FamilyCare services **may supplement**, but not supplant services received by the member.

- Complimentary programs include, but are not limited to, shelter stays, PATH, Social Services for the Homeless, or any non-Medicaid/NJ FamilyCare community-based service.
- For example, where a county or local provider may access funding for comparable housing under another program, the MCO may not require the county or local provider to use that funding before providing and seeking payment or authorization for Housing Supports.

Additionally, Housing Supports providers must not double bill for Housing Supports services.

- A provider **cannot get paid twice by any funding source** (in full or in part) for a Housing Supports service provided to an individual, including across Medicaid and non-Medicaid sources. Double billing or duplicative reimbursement for same service is not permitted. Other available funding should be used to provide additional and complementary services or supports that may benefit NJ FamilyCare members or other community residents depending on the purposes of the funds.
- For example, a provider may not use Residential Modifications and Remediation Services and Children's System of Care environmental modification services to collect double payment for the same modifications to the home.

D. Pre-tenancy and Tenancy Sustaining Services for the First Thirty (30) Calendar Days of Service

Program referrals:

MCOs shall accept outreach by any individual or organization that seeks to refer a member to Tenancy Services but is unsure of their program eligibility (e.g., hospital, primary care physician, public housing agency). For these program referrals, the MCO shall document the following in addition to the referred member information:

- Outreaching entity's name
- Outreaching entity's organization (if any)
- Date of outreach

After receiving a program referral, MCOs shall follow up with the member according to **aggressive outreach**, as defined in the MCO care management workbook (see **Section 15.E**), within 7 business days to support filling out the 'Housing Supports Initial Assessment Tool' either through the phone or, if a member prefers, by directing them to a nearby Tenancy Provider.

Housing Supports connection pathways:

Members can be connected to Housing Supports Tenancy Services in 3 different ways:

- A member receives a program referral from any individual or organization (including MCO self-referral) requesting the MCO to reach out to the member to conduct a service authorization assessment using the 'Housing Supports Initial Assessment Tool'.
- An in-network Tenancy Services provider fills out and submits a 'Housing Supports Initial Assessment Tool' requesting service authorization for the member.
- Any other individual or organization (i.e., not an in-network provider or the MCO) fills out and submits a 'Housing Supports Initial Assessment Tool' on the member's behalf. Before an MCO can proceed with service authorization, MCOs must first reach out to the member to ensure they are interested in having Housing Supports Tenancy Services and to ensure that the member's signature or verbal agreement as defined below in "Forms" below is included in the assessment. If confirm interest in services, the MCO shall connect the member to a provider as needed and provide the submitted assessment to the member's authorized tenancy service provider.

Forms:

To request the start of Housing Supports program services, a **'Housing Supports Initial Assessment Tool'** must be submitted to the MCO or filled out by the MCO. The MCO must accept this standardized authorization form.

In general, it is a best practice to include member signature on the submission of the 'Housing Supports Initial Assessment Tool' to document member interest in services. However, this may not be practical in all cases, and verbal agreement is allowed in the following cases:

- If the MCO completes the initial assessment or document member interest over the phone with the member without requiring a signature; MCOs should accept a member's verbal agreement in place of a signature and document date of member's verbal agreement. After the member

begins services with an in-network Tenancy Services provider, member signature must be collected by the provider to continue services past the first 30 days.

- If an in-network Tenancy Services provider collects and documents member signature, they may submit an authorization request with the MCO over the phone. The provider must keep a record of the member's signature, subject to MCO audit. The MCO should not accept a provider's request for authorization that lacks a member's signature.

All further references to a members' signature for the 'Housing Supports Initial Assessment Tool' in this document should be understood to allow for verbal agreement in the scenarios defined above.

Administrative review (auto-approval):

After receiving the submission of a 'Housing Supports Initial Assessment Tool', the MCO must provide an administrative review of the form to reach an authorization determination. This means that the MCO should check if the form is fully completed (including that the member has signed the assessment, as required notwithstanding exceptions defined in the above section), if the member indicates program eligibility, and ensure that the member isn't already receiving duplicative services. The MCO should not attempt to validate the attestations submitted in the 'Housing Supports Initial Assessment Tool' nor evaluate the assessment beyond the aforementioned checks.

Who can submit:

The Housing Supports program utilizes a "no wrong door" policy for the submission of the 'Housing Supports Initial Assessment Tool'. This means that any entity or individual can submit the 'Housing Supports Initial Assessment Tool' on behalf of any member. As such, MCOs must not deny assessment forms on the basis of who is submitting and should allow pathways for form submission through their provider portal, fax, and telephone.

If a member's 'Housing Supports Initial Assessment Tool' was not submitted by an in-network tenancy provider, the MCO is required to additionally reach out to the member to confirm their interest in receiving Tenancy Services before proceeding with service authorization (see "Turnaround time" in **Section 7.E**).

Attestations:

For the 'Housing Supports Initial Assessment Tool', MCOs must accept attestations of eligibility criteria by the submitter of the assessment. As such, MCOs should not deny authorization in the 'Housing Supports Initial Assessment Tool' due to potentially conflicting eligibility information (i.e., this authorization cannot be denied even if the MCO does not have third-party documentation of the member's clinical risk criteria and/or social risk criteria in their records).

Systems:

MCOs must have systems in place that allow for the submission of the 'Housing Supports Initial Assessment Tool' through their provider portal, fax, and telephone.

Turnaround time:

After receiving the submission of a fully completed 'Housing Supports Initial Assessment Tool,' (including the member's signature) the MCO must note if the submitter of the assessment is an in-network Tenancy Provider.

- **If the submitter is an in-network Tenancy Provider,** the MCO must provide an administrative review of the form making an authorization determination and informing the member within 48 hours during weekdays or 2 business days during weekends and holidays.
- **If the submitter is not an in-network Tenancy Provider,** before the MCO can proceed with service authorization the MCO must first reach out to the member to ensure they are interested in having Housing Supports Tenancy Services and to ensure that the member's signature is included in the assessment. The MCO must do this as soon as possible but at latest within 5 business days[5]. Afterwards, the MCO must provide an administrative review of the assessment form making an authorization determination and informing the member within 48 hours during weekdays or 2 business days during weekends and holidays starting after the member confirms they are interested in having Tenancy Services. The MCO should then provide members timely referrals to a relevant in-network Tenancy Service provider within 7 calendar days from service authorization approval (see "Provider referrals" below).

A business day is defined as a 24-hour period on weekdays (Monday – Friday), excluding holidays observed by State of New Jersey (see https://www.nj.gov/nj/about/facts/holidays/).

If the MCO does not meet turnaround time requirements to make an authorization decision based on a fully completed 'Housing Supports Initial Assessment Tool' as detailed above, the authorization request should be automatically approved.

Duration:

The approval of the 'Housing Supports Initial Assessment Tool' provides authorization for services for 30 calendar days. The start of services is defined as:

- **If an in-network Tenancy Provider submitted the 'Housing Supports Initial Assessment Tool'**: MCOs shall retroactively approve services starting from the date the provider submitted the initial request for services.
- **If the 'Housing Supports Initial Assessment Tool' was not submitted by an in-network Tenancy Provider**: MCOs shall approve services starting from the day an in-network provider starts delivering services[6]. Providers should notify MCOs when they start services by adding a member touchpoint in the relevant HMIS individual file. If a member is unable to be documented in HMIS (i.e. member is receiving services from a VAWA-funded shelter), the member touchpoints must be documented in a HMIS-comparable system, notwithstanding the services dictionary.

Provider referrals:

If a member is approved for Tenancy Services through the 'Housing Supports Initial Assessment Tool' and does not indicate a connection to a program provider, MCOs should reach out to members according to aggressive outreach as defined in the MCO care management workbook (see **Section 15.E**) to provide timely referrals to Tenancy Providers in a timeline consistent with the "Turnaround time" section above.

[5] If a member is unable to be contacted by the MCO within the 5 business days, MCOs should deny service authorization

[6] If an out-of-network provider submits the 'Housing Supports Initial Assessment Tool', the out-of-network provider should either refer the member to an in-network provider or let the MCO identify an in-network provider for the member to begin services.

If a member is approved for Tenancy Services through the 'Housing Supports Initial Assessment Tool' and was referred by a provider not in-network with the MCO, then the MCO may re-assign the member to an in-network provider. MCOs may also establish Single Case Agreements consistent with existing MCO policies; however, MCOs are encouraged to credential and contract the referring out-of-network provider if eligible and willing to join.

Incomplete submissions:

In the case of an incomplete 'Housing Supports Initial Assessment Tool' submission, the MCO must reach out to the entity that made the initial request for services or the member at least 3 times within 5 business days to finish the form before providing an authorization denial.

Denials:[7]

MCOs should only exercise an authorization denial for a completed and member signed 'Housing Supports Initial Assessment Tool' submission if at least one of the following is true:

- The member lacks indication in the form that they meet the eligibility criteria
- The member is already receiving duplicative Medicaid/NJ FamilyCare services either through a household member or themselves (see **Section 7.C**)

E. Pre-tenancy and Tenancy Sustaining Services Past the First Thirty (30) Calendar Days of Service (Necessity Review Service Authorization Process)

Forms:

To request the continuation of Housing Supports program services beyond the first 30 days, a necessity review service authorization process must be followed. This means, that both a **'Level of Need Assessment'** (to determine "high" versus "low" need member billing) and a **'Housing Stabilization Plan'** (to ensure appropriateness of services) must be submitted to the MCO. The MCOs must accept these standardized forms (see **Section 16**) and use them to validate member eligibility and need for program services.

In order to review the 'Housing Stabilization Plan' and justify a member's need for program services, MCOs must use the state-defined **'Housing Stabilization Plan Rubric'** (see **Section 16**) to check for **completeness of the plan**. When reviewing the 'Housing Stabilization Plan,' MCOs should ensure that all areas of the 'Housing Stabilization Plan' are filled out including at least 1 goal and action for each of the 3 plan components (i.e., housing, health, income) as well as ensuring that the plan has all necessary signatures and responses to questions.

In addition, until July 1, 2026, MCOs should use an additional state-defined **'Non-evaluative Housing Stabilization Plan Rubric'** (see **Section 16**) to review a subset of 'Housing Stabilization Plans' for reporting purposes only. Each quarter, MCOs should review either 20 plans or 2% (1 out of every 50) of all submitted plans, whichever number is greater. This additional review should not impact authorization decisions and MCOs should record performance metrics as defined by DMAHS (see **Section 13.A**).

[7] MCOs should not deny authorization if a provider does not render services in the authorization window. Providers are expected to only submit a claim if they deliver the minimum required services to the member.

DMAHS will stand up a working group with MCOs, housing supports providers, and other stakeholders to refine the service authorization process and the review of the 'Housing Stabilization Plan.' DMAHS plans to use the working group proposal to update the 'Housing Stabilization Plan Rubric' for the review of the 'Housing Stabilization Plan' starting first half of 2026. However, until this Guidance is updated, the current approach to reviewing the 'Housing Stabilization Plan' (i.e., completeness) will continue to define program rules.

For reauthorizations beyond the first 180 days of service, the MCO should perform a necessity review service authorization process again with updated forms checking for continued member eligibility and need for program services**.**

MCOs **must not require additional documentation** to come to an authorization decision but can utilize their internal systems data (e.g., claims data), any HMIS data, and ask questions of providers to clarify and validate eligibility and/or member need for program services, or may request updated completed versions of required documentation for authorization.

Who can submit:

For the necessity review service authorization process, both the 'Level of Need Assessment' and the 'Housing Stabilization Plan' must be submitted to the MCO by their **in-network tenancy service provider** authorized to give the member their services.

Systems:

MCOs must have systems in place that allow for the submission of the 'Level of Need Assessment' and the 'Housing Stabilization Plan' through their provider portal and fax.

Turnaround time:

After receiving the submission of a fully completed 'Level of Need Assessment' and 'Housing Stabilization Plan,' the MCO must complete review of the forms, make an authorization determination, and inform the member and provider within 7 calendar days from the provider's submission of both completed forms.

If the MCO does not meet turnaround time requirements, the authorization request should be automatically approved.

Duration:

The initial necessity review for authorizations occurs following the first 30 days of service and extends authorization through the next 150 calendar days, for a total of 180 calendar days of service.
If the member is requesting authorization beyond the first 180 calendar days of services through a reauthorization request, the approval of the necessity review forms provides authorization for services for the next 180 calendar days.

If a provider submits an authorization request after the end of services, the MCO must accept and allow for retroactive approval of service authorization requests up to 5 days after the end of an authorization period (consistent with other program rules) such that there is no gap in the member's services. The MCO may retroactively approve authorization requests that are submitted more than 5 days late, at the MCO's discretion.

Housing Stabilization Plan:

Once the 'Housing Stabilization Plan' is submitted to the MCO and is approved, the relevant MCO care manager should coordinate with the Housing Specialist to look through the Tenancy Provider's housing stabilization plan to update the member's MCO care plan accordingly.

Change in member authorization elements:

It is possible that a member's plan of care (and subsequently, their authorization element) may need to change during their authorization for services. MCOs should accept and process new authorizations submitted via the following processes, based on the scenario.

Change in member's provider:
If the member has a change in Housing Supports provider mid-services, the new provider must request service authorization and the MCO should authorize services for 180 calendar days, while simultaneously ending the authorization for the previous provider. This process involves:

- New provider requests service authorization for 180 calendar days using the necessity review service authorization process.
- MCO verifies the member's intent to switch providers through either
    - Verbal conversation between the member and their MCO Housing Specialist; or
    - Written communication with the MCO (e.g., email or as signature in new authorization request).
- MCO makes determination of the new authorization.
    - If approved, the MCO closes out previous authorization from the previous provider and notifies the previous provider.
    - If denied, the MCO notifies the new provider and member of denial and keeps the previous authorization as is (i.e., does not end the previous authorization and the member may continue receiving services under the previous authorization).

Change in member's MCO:
If the member has a change in MCO mid-services, the provider must first call the new MCO and submit a new authorization request through the necessity review service authorization process for 180 calendar days of services. As per continuity of care guidelines, the new MCO is required to allow in-network providers to continue providing the service until a new MCO plan of care is identified.

If the provider is out-of-network of the new MCO, the new MCO should establish a single case agreement[8] until a new plan of care is established and identify and approve an in-network provider for the member as soon as possible.

When a new authorization is received by the new MCO after a member switches MCOs, the new MCO must retroactively date the authorization to the first date of the member's enrollment with the new MCO. If the provider does not submit an authorization and submits a claim, then the new MCO may deny the claim and initiate a conversation with the provider requesting a new authorization request for 180 days to be submitted.

[8] Single case agreements can be used in other scenarios at the MCOs discretion.

See **Section 7.H** for MCO responsibilities on requesting document transfer when members switch MCOs.

Change in member's level of need:
If the member has a change in need (e.g., billing at a "low" rate originally and has had major life changes and now meets criteria for billing at a "high" rate), the provider should submit a new authorization request with relevant updates through the necessity review service authorization process for 180 calendar days of services.

If the new authorization approved, then the MCO should start the new authorization and simultaneously end the previous authorization after the current 30-day billing period under the previous authorization ends. In other words, a 180-day authorization includes six 30-day billing periods. If, for example, a member is receiving Pre-Tenancy Services at "low" level of need and their provider submits a new authorization for a "high" level on the 14th day of any given 30-day billing period, the new authorization will take effect after the 30 days in that billing period has ended (i.e., on the 1st day of the new billing period).

If the new authorization is not approved due to not demonstrating need for the new level of need, then the previous authorization should remain as is, and the member should continue receiving services under the previous authorization.

Change in member's services:
If the member has a change in service need (e.g., from Pre-tenancy to Tenancy Sustaining Services), the provider should submit a new authorization request with relevant updates through the necessity review service authorization for 180 days of services.

If the new authorization is approved, then the MCO should start the new authorization and simultaneously end the previous authorization after the current 30-day billing period under the previous authorization ends (same process as if a change in level of need is approved). If the new authorization is not approved due to not demonstrating need for the new service, then the previous authorization should remain as is, and the member should continue receiving services under the previous authorization.

General Notes:
In any of the scenarios above, the new authorization request must be conducted under the necessity review process, and the MCO should authorize services for the next 180 days, if approved. For example, if on a member's current authorization ends on day 100 and the new authorization begins, the member now has an additional 180 days of service, allowing them to continue receiving services, if necessary, until day 280.

In situations of combined scenarios above (e.g., if the member has both a change in type of services and a change in providers), then the authorization process for a change in provider or MCO should take precedent over the authorization process for a change in level of need or change in member services (i.e., if approved, authorization begins on the day of submission, not at the end of the current billing period in a combined scenario).

Denials:

MCOs can issue authorization denials during the necessity review service authorization process if the MCO finds at least one of the following conditions:

- The member's 'Housing Stabilization Plan' does not reasonably document necessity through incompleteness by the 3rd submission from the provider (i.e., the MCO has requested and the provider has already resubmitted the 'Housing Stabilization Plan' at least twice during the same authorization request)
- Provider does not submit a complete 'Level of Need Assessment' (i.e., lacks a final score based on the assessment and/or other non-scored fields requested)
- The member fails to meet the program's eligibility criteria
- The member is receiving duplicative Medicaid/NJ FamilyCare services either through a household member or themselves

MCOs shall notify the provider if the 'Housing Stabilization Plan' doesn't reasonably document necessity and should identify and inform the provider of the needed revisions for their resubmission. As noted above, MCOs must allow providers the opportunity to update and resubmit the member's 'Housing Stabilization Plan' at least 2 times before issuing an authorization denial. Each resubmission has a 7-day turnaround time in which the MCO must either approve, deny, or request a resubmission from the provider.

F. Residential Modifications and Remediation Services, and Move-in Supports

Authorization:

Residential Modifications and Remediation Services, and Move-in Supports, must be authorized by MCOs. These services must be determined to be necessary. The authorization process seeks to be consistent with how MCOs authorize MLTSS Modification Services today. The authorization process is not the same as is used for Pre-tenancy or Tenancy Sustaining Services, described above.

The authorization process takes place in 6 steps:

- **Member Referral**: a member is connected to Residential Modifications and Remediation Services or Move-in Supports. A member, family member, Housing Supports provider, or other interested party including the member's care manager or Housing Specialist may submit the "Initial Assessment Tool" to the MCO. **Note:** for these services, this submission is not auto-approved, like the initial request for Tenancy Services, as described above.
- **1st MCO Decision**: the MCO decides if the member meets program eligibility, demonstrates necessity for these services, and does not have any other program limitations (e.g., already exceeded lifetime caps). The MCO may collect additional information on member needs; this process and decision criteria varies by MCO. The MCO must communicate its determination to the member and the referrer. In addition, if the provider delivering the service is separate from the referrer, the MCO must communicate its determination to the member, the provider delivering the service, and the referrer.
    - For **Move-in Supports**, if the member already has an in-network provider through Pre-tenancy or Tenancy Sustaining Supports, the provider has the option to deliver Move-in Supports. If not, the member's MCO may decide who will deliver the services (i.e., the MCO or an in-network Tenancy provider or Residential Modifications and Remediation provider).

    - For **Residential Modifications and Remediation Services**, the MCO's approval at this stage will authorize 1 or more in-network Residential Modifications and Remediation providers to conduct evaluations (i.e., price quotes on the cost of services).
- **Request for Info**:
    - For **Move-in Supports**, the party designated to deliver services above (i.e., provider or MCO) develops an itemized goods/service list for member needs, including the cost of goods/services. If the provider is delivering the services, they must share the list to the MCO for review.
    - For **Residential Modifications and Remediation Services**, the providers authorized to prepare evaluations conduct and submit their evaluations to the MCO. Note: the Services Dictionary includes 'approval requirements' that may be collected at this stage, or earlier in the process (e.g., property owner consent).
- **2nd MCO Decision:**
    - For **Move-in Supports**, the MCO makes an authorization decision to approve the service and total spending amount**.** In addition, MCOs may define a timeline for the provider to deliver goods and services.
    - For **Residential Modifications and Remediation Services**, the MCO selects a provider based on the evaluations and authorizes the provider to deliver the service.
    - **Note:** The 7-calendar day turnaround time (defined below) only applies to this step.
- **Service Delivered:** The approved provider or MCO delivers the services.
- **MCO Follow-Up:** The member's Housing Specialist or care manager should communicate with the member to ensure successful delivery of services[9].

Limitations on service authorization:

MCOs shall make an authorization determination in accordance with limitations denoted in the services dictionary (see **Section 15.A**).

Move-in Supports is defined as "non-recurring, one-time transitional expenses provided to a member during the transition period to their own home." Move-in Supports are limited to one 'moving experience' per lifetime per member. A 'moving experience' may entail multiple service authorizations and does not have a state-determined time limit, notwithstanding the services dictionary (see **Section 15.A**).

If a member transfers between MCO plans, the MCOs must transfer required information on current and previous service utilization, including spend on these services up to the lifetime cap (see **Section 7.H**).

Turnaround time:

For members requesting Residential Modifications and Remediation Services or Move-in Supports services, MCOs must make an authorization determination after receiving a complete authorization request within 7 calendar days from referral to authorization (see authorization process flow step "2nd MCO Decision" defined above). For Residential Modifications and Remediation Services where multiple bids are involved, the 7-day turnaround time applies to each completed bid received. MCOs have the

[9] If the member has neither a MCO Care Manager or Housing Specialist, the MCO may follow up with the provider to confirm delivery of services.

discretion to extend the turnaround time for a bid if waiting on an outstanding bid, if within a reasonable timeframe. This turnaround time does not require that the timeline from referral to service delivery is 7 calendar days.

G. Appeals of Housing Supports Services

MCOs must ensure systems exist for members and/or providers who disagree with authorization determinations to submit an appeal (as required in the MCO contract). To identify services that are not eligible for IURO (Independent Utilization Review Organization) review refer to Contract Article 4.6.4.C.4.c.

H. Members Switching MCOs

For members who switch MCOs during an active authorization period for any Housing Supports service, MCOs must have mechanisms in place to transfer documents from the prior MCO to the new MCO.

Housing specialists and/or housing managers at the prior and new MCO should coordinate with each other, the provider(s), relevant MCO staff, and member (if necessary) to coordinate transfer of data.

Housing Specialists at the receiving MCO should contact a Housing Specialist at the prior MCO to request the transfer of documentation upon the member's enrollment. The following minimum documentation should be shared within 7 days of the request:

- **For Tenancy Services:**
  - Documentation of completed tools and assessments, relevant Housing Specialist notes, and what the member was authorized for associated with the member's current authorization and/or any prior authorizations within 30 days of each other
  - Care management documentation should be transferred pursuant to the MCO contract
- **For Residential Modifications and Remediation Services & Move-in Supports:**
  - Documentation of completed tools and assessments, relevant Housing Specialist notes, and what the member was authorized for associated with the member's current authorization
  - Documentation of all historical spend tracking (e.g., itemized lists, services delivered) for the member and any documentation of duplication for member's household identified during service authorization

See **Section 7.E** for additional details on how the receiving MCO should continue the member's plan of care.

8. Care Management

A. Enrollment into Care Management

All households authorized for Pre-tenancy or Tenancy Sustaining Services are eligible and should be assessed for care management services (not withstanding MCO contract provisions that may require all members are automatically enrolled). As such, the member of the household who is authorized for Tenancy Services should complete a Comprehensive Needs Assessment within 30 days after the initial

approval for Pre-tenancy and Tenancy Sustaining Services unless the member opts out or has already completed an assessment[10].

If enrolled into care management, each household receiving Tenancy Services may jointly attend combined care manager sessions. This means:

- Only the member with whom services are authorized under counts towards the care management caseloads (e.g., a mother and 4 children count as 1 member towards a care manager's caseload not 5 members).
- Only 1 care management care plan is created for the member under which services are authorized but this plan should collectively benefit the member's household.

Additionally, the Initial Health Screen (IHS), Comprehensive Needs Assessment (CNA), and the Trigger Events list have been updated with additional screening questions to identify housing needs and ensure that all those who receive a Housing Supports program referral are eligible for care management assignment (see **Section 15.E**).

[10] If a member is unable to be contacted through outreach, Member can be considered to have opted out. Moreover, members in MLTSS and certain other NJ FamilyCare programs are already enrolled into care management by default. As such, they don't need to be assessed again for care management.

B. Delivery of Care Management

Members benefit differently from MCO and housing supports provider, with Housing Specialist responsible for most MCO housing care mgmt. responsibilities

	MCO care managers All services	**MCO Housing Specialist** Tenancy Services	**Housing Supports Providers** Tenancy Services
Definition	**Primarily office-based** care managers help members achieve **biopsychosocial goals and health outcomes** Make **referrals** to physical heath and behavioral health providers	**Primarily office-based** housing specialists help members achieve **housing goals** Make **referrals** to Housing Supports program providers[1]	**Field-based services** to connect members to resources and to **find & maintain housing**, by: • Searching for housing • Completing applications for government assistance • Assisting with lease renewals
Unique benefit to members	Access member's medical history and health data Connect member to health care providers/experts to ensure access to care encompassing all aspects of member needs	Provide regional expertise on the housing ecosystem, key organizations and players Connect members to most relevant housing services	Find and maintain member's housing Provide deep expertise on the housing ecosystem On-the-ground understanding of member's needs and environment

1. And other housing services programs outside of Medicaid at the end of Housing Supports program services

Exhibit 5. MCO Housing Specialists handle most member-facing MCO interactions for the Housing Supports program instead of the MCO care manager.

For Housing Supports program services, MCO care managers and Housing Specialists must work collaboratively by sharing member updates (i.e., provider referrals, service monitoring, and any engagement with providers) and leveraging the Housing Specialist's expertise when more specialized housing knowledge would prove beneficial to the member. At the same time, both physical and behavioral health MCO care managers should receive training on housing topics including the Housing Supports program.

Additionally, MCO housing services manager is responsible for aiding Housing Specialists and improving their coordination with MCO care managers by ensuring a common approach to member and provider engagement.

9. Housing Specialist

A. Overview of Housing Specialist

Housing specialist responsibilities divided among 3 positions

Member- and provider-facing
Housing specialist
Existing position

Housing specialist to **own member-facing engagements** for members receiving Pre-tenancy Services and Tenancy Sustaining Services

Responsibilities:
- Make provider referrals
- Ensure timely start of services
- Support development of **member's care plan**
- **Monitor member's services**, diagnosing & solving pain points
- Provide **warm handoff** of member at end of services
- Provide housing services to MLTSS and nursing home transition segments; coordinating Healthy Homes placement
- Build meaningful relationships with provider community

Internal training and oversight
Housing services manager
New position

Housing services manager to oversee Housing Specialists and build MCO **housing expertise**

Responsibilities:
- **Advise Housing Specialists** on tough cases
- Support **MCO credentialing**
- Conduct housing **trainings for Housing Specialists and care managers**
- Review housing stabilization plan during authorization requests

Internal program director
Housing services director
Previously titled housing services mgr.

Housing services director provides **oversight** for Housing Specialists and housing services managers

Responsibilities:
- Manage team of Housing Specialists and housing services managers
- Responsible for **overall implementation** of the housing supports program across MCO

No change in existing responsibilities from latest contract

Exhibit 6. Overview of the 3 housing expert roles within the MCOs.

B. Responsibilities

The MCO Housing Specialist is a position that currently exists in the MCO and has responsibilities for MLTSS members and Healthy Homes members. The Housing Specialist will retain all of their previous responsibilities coordinating Healthy Homes program placement[11] and providing housing services to the MLTSS population if they aren't eligible for Pre-tenancy or Tenancy Sustaining Housing Supports program services. In addition, the Housing Specialist will now also have responsibilities for the Housing Supports program.

For the Housing Supports program, the Housing Specialist will be a member- and provider-facing position assigned to those receiving Housing Supports program Pre-tenancy and Tenancy Sustaining Services. The Housing Specialist is responsible for utilizing their regional housing expertise to make informed Housing Supports program provider referrals, ensuring services are delivered by the providers by conducting proper monitoring, supporting the MCO care manager's development of the housing aspects of the member's MCO care plan, and providing a warm handoff to members at the end of program services.

C. Staffing Qualifications

MCOs must designate their Housing Specialists to specific geographic specializations based off Continuum of Care (CoC) catchment areas where they are or will be trained to become the MCO's

[11] See Healthy Homes program guidance linked here (https://www.nj.gov/dca/divisions/dhcr/offices/docs/bh/njhealthhomesguidelines.pdf).

expert on housing in their designated region(s). Collectively across Housing Specialists, geographic designations must cover the whole state of New Jersey. Each Housing Specialist can be assigned to one or more CoC catchment area[12]. If the MCO has more than one Housing Specialist, no Housing Specialist should be assigned all CoC catchment areas.

D. Staffing Ratios

MCO Housing Specialist caseloads can be mixed across programs but must not exceed 150 weighted members (household members not directly authorized for services are not counted). Caseload weights are defined by the member under which services are authorized as follows:

- **Housing Supports program members:** "High" need Housing Supports members have a weight of 2 while "low" need members have a weight of 1. “High” versus “low” need is determined by the standardized 'Level of Need Assessment' and corresponds to billing rates. Members who opt out are still counted within caseloads, however at 50% of members who do not opt out (i.e., “high” need Housing Supports members who opt out have a weight of 1, while “low” need Housing Supports members who opt out have a weight of 0.5). Housing specialists expected to support initial referral and provider-facing engagements.
- **Healthy Homes members:** Healthy Homes members shall count towards Housing Specialist caseloads with weight of 1 unless they are already counted towards caseloads with a weight of 1 or 2 due to participation in the Housing Supports program.
- **MLTSS members:**
    - MLTSS members currently served by MCO Housing Specialists that are **eligible for the Housing Supports program** and are shifted into the Housing Supports program count towards caseload caps as determined by their 'Level of Need Assessment'.[13]
    - MLTSS member currently served by MCO Housing Specialists that **aren’t eligible for the Housing Supports program** should continue receiving Housing Specialist services and count towards caseload caps with a weight of 5.

MCOs are expected to adequately hire Housing Specialists to meet twice the caseload caps by July 2025 (i.e., Housing Specialists can have a weighted member caseload cap of up to 300). **MCOs are expected to hire to meet actual caseload caps by January 2026** (i.e., Housing Specialists to have at most a weighted member caseload of 150).

[12] See CoC catchment areas linked here (https://www.nj.gov/dca/dhcr/offices/CoC.shtml)

[13] If member has a strong desire to not receive services from a Housing Supports program provider, member can continue to receive services as is with a case weight of 5.

	Housing specialist
Caseload cap	1:150 weighted cap
Housing Supports members	• Members who do not opt out: "high" need member counts as 2 towards caseloads; "low" need member counts as 1 towards caseloads • Members who opt out: "high" need member counts as 1 towards caseloads; "low" need member counts as 0.5 towards caseloads
Healthy Homes members	Counts as 1 towards caseloads, unless already counted towards caseloads due to participation in Housing Supports program
MTLSS members	**If eligible for Housing Supports**, member to be shifted into Housing Supports • Counts towards caseloads as any other Housing Supports member **If not eligible for Housing Supports but already receiving comprehensive Housing Specialist services,** should continue receiving services • Counts towards caseloads with a weight of 5
Nursing home transition members	Does not count towards caseloads • Continues to be served only by dedicated nursing home transition specialists

Exhibit 7. Overview of Housing Specialist Caseloads.

E. Housing Specialist Enrollment

All households receiving Housing Supports Pre-tenancy or Tenancy Sustaining Services are assigned a Housing Specialist unless they opt out. Since Housing Specialist assignment is made by household, only the member under which services are authorized for counts towards Housing Specialist caseload caps).

Housing specialist assignment must occur within two business days after program referral or auto-approval authorization if the member needs a referral to a Pre-tenancy Services or Tenancy Sustaining Services provider or as soon as possible but no later than 30 calendar days after service authorization if the member is already connected to a Pre-tenancy or Tenancy Sustaining Services provider.

After program referral but before auto-approval authorization, Housing Specialists can be assigned to any member regardless of their location in order to assist the member to either fill out the 'Housing Supports Initial Assessment Tool' or direct them to a nearby Tenancy Services provider to do the same. These members do not count towards Housing Specialist caseloads as they may be highly temporary assignments.

After auto-approval authorization of services, Housing Specialists should be assigned to members located in their geographic specialization area to ensure that members receive regional expertise most relevant to them.

F. Housing Specialist Delivery

The following are required responsibilities of the MCO Housing Specialist for the Housing Supports program members in their caseloads:

- **Make and follow up on program referrals:** MCO Housing Specialists should reach out to members who receive a program referral to Housing Supports program Tenancy Services

ensuring their interest in receiving program services and supporting them to fill out the 'Housing Supports Initial Assessment Tool' either through the phone or, if the member prefers, by directing them to a nearby Tenancy Provider.

- **Aid in MCO care plan development for housing:** At most 30 days after CNA completion, MCO care managers should develop an MCO care plan that must include short/long-term housing goals that are actionable and have measurable quality outcomes. MCO Housing Specialists should jointly create housing goals inside of the MCO care plan with the MCO care manager and the member.
- **Make provider referrals:** MCO Housing Specialists must conduct member outreach to facilitate a timely warm referral according to aggressive outreach standard as defined in the MCO Care Management workbook (see **Section 15.E**). Outreach should be completed within 7 days after auto-approval if the member is not already connected to a Tenancy Services provider or 30 days if the housing supports provider referral is based on needs identified in the member's MCO care plan.
- **Ensure timely delivery of services:** If the member's services are not initiated within 2-weeks for Tenancy Services or 30-days for Residential Modifications and Remediation Services and Move-in Supports after authorization, then Housing Specialists must diagnose service delay and take action to support the member.
- **Monitor member services:** MCO Housing Specialist should reach out to members in their caseloads according to aggressive outreach (as defined in the MCO Care Management Workbook, see **Section 15.E**) to ensure services are delivered appropriately and to diagnose any pain points in service delivery. Outreach to monitor member services should occur at least once every 180 days for "low" need members or once every 90 days for "high" need members. "High" and "low" need is defined by the 'Level of Need Assessment'.
- **Monitor providers:** MCO Housing Specialist must reach out to tenancy providers serving the members in their caseloads according to aggressive outreach (as defined in the MCO Care Management Workbook, see **Section 15.E**) to ensure services are being delivered appropriately to the member and to diagnose any member pain points at least once every 180 days for "low" need members or once every 90 days for "high" need members. Like above, "high" and "low" need is defined by the 'Level of Need Assessment'[14]. If a member assigned to an MCO specialist opts out, the MCO specialist must still maintain provider engagement for that member.
- **Provide warm handoff of services at the end of program authorization:** MCO Housing Specialists should, at latest 14 days after authorization denial or after being informed of termination of Pre-tenancy Services or Tenancy Sustaining Services, use aggressive outreach (as defined in the MCO Care Management Workbook, see **Section 15.E**) to the member and consult the member on other housing services options if the member has ongoing needs. In addition, MCO Housing Specialists should be available to explain to providers the rationale if the member's service authorization was denied.
- **Coordinate document transfer when members switch MCOs:** if member participates in Housing Supports, coordinate collection of required documents and transfer to Housing Specialist(s) at receiving MCO within 7 calendar days of request; when receiving a member, reach out to Housing Specialist(s) at previous MCO to request documentation and, upon receiving, ensure relevant systems & teams (e.g., authorization) are updated.

[14] If issues are identified during monitoring, Housing Specialists should attempt to resolve through conversations. If resolution is unsuccessful, member should be provided the opportunity to be connected to a new in-network provider.

- **Build meaningful relationships with the provider community:** be active participant in meetings, trainings, and other forms of engagement to integrate with provider community.

G. Trainings

MCO Housing Specialists must attend no fewer than 1 housing-focused training per quarter of a calendar year. These trainings should be delivered by or coordinated by the MCO housing services manager to achieve greater Housing Specialist expertise in the housing ecosystem.

H. Monitoring

DMAHS may request MCOs to report quarterly:

- Number of Housing Specialist currently employed including their geographic specialization
- Each Housing Specialist's caseloads by member population, level of need, and opt out status
- Number of members receiving Tenancy Services and assigned a Housing Specialist
- Time to start of Tenancy Services from authorization stratified by referral source
- Tracker of Housing Specialist activities by member including touchpoints (e.g., outreach attempts, members contacted last month, updated MCO care plan)

See quality reporting (**Section 13** below) for more details.

DMAHS will additionally update the annual member satisfaction survey to include Housing Specialist questions for MCOs to use.

I. HMIS

Because MCO Housing Specialists should monitor services of members in their caseloads, MCOs must set up New Jersey HMIS accounts. This will allow MCOs to track, in near-real time, Pre-tenancy and Tenancy Sustaining Provider member touchpoints to validate that services are being delivered with at least the required minimum number of touchpoints (i.e., 2 touchpoints per month for "low" need members and 4 touchpoints per month for "high" need members). DMAHS will provide additional guidance to MCOs on how to set up these accounts. **Note:** Pre-tenancy and Tenancy Sustaining Providers are required to track their touchpoints in HMIS. If a member is unable to be documented in HMIS (e.g., member is receiving services from a VAWA-funded shelter), the member touchpoints must be documented in a HMIS-comparable system, notwithstanding the services dictionary. If a provider does not meet touchpoint requirements for a month of services, they should not submit a claim for billing.

10. Housing Services Manager

A. Overview of Housing Services Manager

Housing specialist responsibilities divided among 3 positions

Member-facing
Housing specialist
Existing position

Housing specialist to **own member- facing engagements** for members receiving Pre-tenancy and Tenancy Sustaining Services

Responsibilities:
- Makes provider referrals
- Ensure timely start of services
- Supports development of **member's care plan**
- **Monitor member's services**, diagnosing & solving pain points
- Providing **warm handoff** of member at end of services
- Providing housing services to ML TSS and nursing home transition segments; coordinating Healthy Homes placement

Internal training and oversight
Housing services manager
New position

Housing services manager to oversee Housing Specialists and build MCO **housing expertise**

Responsibilities:
- **Advise Housing Specialists** on tough cases
- Supports **MCO credentialing**
- Conduct housing **trainings for Housing Specialists and care managers**
- Reviews housing stabilization plan during authorization requests

Internal program director
Housing services director
Previously titled housing services mgr.

Housing services director provides **oversight** for Housing Specialists and housing services managers

Responsibilities:
- Manage team of Housing Specialists and housing services managers
- Responsible for **overall implementation** of the housing supports program across MCO

No change in existing responsibilities from latest contract

Exhibit 8. Overview of the 3 housing expert roles within the MCOs.

B. Responsibilities

For the Housing Supports program, the MCO housing services manager will be an MCO-internal manager position with the following responsibilities:

- Overseeing the MCO Housing Specialists ensuring they have needed advice and expertise especially on tougher member cases (main responsibility)
- Playing advisory role during the MCO credentialing process for Housing Supports providers
- Creating and conducting housing-related trainings for Housing Specialists and MCO care managers
- Sampling and evaluating housing stabilization plans to provide feedback to Tenancy Providers (evaluation does not impact service authorization at this time; see **Section 7.E.**)

As noted in the care management section above, MCO housing services managers are further responsible for aiding Housing Specialists and improving their coordination with MCO care managers by ensuring a common approach to member and provider engagement.

C. Staffing Qualifications

Housing services managers must be familiar with relevant public and private housing resources and stakeholders (e.g., know of DCA OHP, HUD, different types of community-based organizations like homeless shelters, etc.), and should have, at a minimum, at least 1 of the following qualifications:

- 2 years of experience as an MCO Housing Specialist; or,

- 3 years of experience assisting vulnerable populations to secure accessible, affordable housing and a bachelor's degree in social work or similar degree (e.g., psychology, social sciences, nursing, or otherwise approved by DMAHS upon request to these qualifications).

D. Staffing Ratios

MCO housing services managers should act as the Housing Specialists' supervisors where every Housing Specialist is assigned one housing services manager. No housing services manager can manage more than 8 Housing Specialists at any given time.

MCOs must adequately hire to ensure housing services managers meet 1:16 (manager to Housing Specialist) ratios caps by July 2025 and 1:8 ratio caps by January 2026.

E. Housing Services Manager Delivery

MCO housing services managers have at a minimum the following responsibilities:

- **Oversee and provide expertise to MCO Housing Specialists** with weekly 1:1 meetings and sitting in on tough member calls where the Housing Specialist requires additional help.
- **Create and conduct trainings** at least once a quarter on Housing Supports topics for MCO care managers and Housing Specialists. MCO Housing Specialists are required to attend at least one training per quarter. Examples of training topics may include detail on Housing Supports services, provider networks, or best practices for service delivery (e.g., non-housing services/issues that impact housing work). Housing services managers are not required to create original trainings; they may leverage or adapt existing trainings from DCA Office of Homelessness Prevention, other MCOs, or other reputable sources, where appropriate.
- **Provide housing expertise by serving as advisor during credentialing.** Housing services manager should help in evaluating the experience of potential Housing Supports providers (particularly those not "deemed") during the Contractor's credentialing process.
- **Sampling and providing feedback on housing stabilization plans.**
    - Until July 1, 2026, reviewing the greater of 20 or 1 in 50 of every submitted 'Housing Stabilization Plans' per quarter through the 'Non-evaluative Housing Stabilization Plan Rubric' (see **Section 16**). This review will provide feedback to Housing Supports providers and inform the future development of a determinative housing stabilization plan rubric. Through July 1, 2026, this review is not to be used to make an authorization decision.
    - DMAHS plans to share a further refined 'Housing Stabilization Plan Rubric' to be used for authorization determinations starting first half of 2026.

F. Monitoring

In addition to Housing Specialist reporting requirements, MCOs must submit to DMAHS quarterly the number of housing services managers currently employed within the same reporting form. See quality reporting (**Section 13** below) for more details.

MCOs must also provide to the Department's Office of Managed Health Care a quarterly report detailing trainings Housing Specialists have attended, ensuring that Housing Specialists attend no fewer than 1 housing focused training per quarter of a calendar year.

11. Housing Services Director

A. Overview of Housing Services Director

Housing specialist responsibilities divided among 3 positions

Exhibit 9. Overview of the 3 housing expert roles within the MCOs.

B. Responsibilities

For the Housing Supports program, the MCO housing services director (previously titled "housing services manager" in the 2024 MCO contract) will be an MCO-internal director position whose main role is overseeing all of the MCO's housing related services (e.g., MLTSS housing, Healthy Homes, Housing Supports, and any future housing programs). In particular, the housing services director should manage the housing services managers and oversee the Housing Specialists to ensure that caseload and management ratios follow all requirements, as specified in **Sections 9 and 10 above**. In addition, the housing services director shall be responsible for the overall implementation of the Housing Supports program across the MCO, leading the readiness to program launch.

C. Staffing Qualifications

MCOs may define reasonable qualifications and should hire a qualified MCO housing services director. At this time, DMAHS does not have specific qualification requirements for this position.

D. Staffing Level

MCOs must employ 1 housing services director. This position was previously titled the "housing services manager" in the 2024 MCO contract; the individual hired for this position may count toward this newly titled position.

E. Monitoring

MCOS must report to DMAHS quarterly the number of housing services directors currently employed.

12. Payment and Claims

A. Payment Structure and Amount

Rate Structure and amounts:

Payment structure and amount for Housing Supports services is described in **Section 15.C**.

The **rate amounts for Pre-tenancy and Tenancy Sustaining Services are standardized across all MCOs**. All MCOs are required to pay providers according to this uniform fee schedule. Payment for Pre-tenancy and Tenancy Sustaining Services is structured as a per member per month (PMPM).

- **Payment Structure:** For Pre-tenancy and Tenancy Sustaining Services, the MCO shall pay a per member per month (PMPM) rate, stratified by higher and lower level of need as determined by the standardized Housing Supports Level of Need Assessment Tool completed by the Tenancy Provider and approved by the MCO during service authorization.
- **Billing Period:** For the purposes of billing, a "month" is typically defined as a 30-day billing period, that aligns to the member's service authorization period.
    - The 30-day billing period starts on the first day of the service authorization and continues for 30 days or until the service authorization ends, whichever is later.
    - For example, if a member receives a 180-day authorization for Pre-tenancy Services, this service authorization will be defined by six 30-day billing periods.
- **"High" Touchpoint Requirements:** If a member is authorized for a higher level of need, then the Tenancy Provider must deliver 4 or more touchpoints per billing period and document those touchpoints in HMIS. If a member is unable to be documented in HMIS (e.g., member is receiving services from a VAWA-funded shelter), the member touchpoints must be documented in a HMIS-comparable system, notwithstanding the services dictionary. See below for definition of a valid touchpoint.
- **"Low" Touchpoint Requirements:** If a member is authorized for a lower level of need, then the Tenancy Provider must deliver 2 or more touchpoints per billing period and document those touchpoints in HMIS. If a member is unable to be documented in HMIS (e.g., member is receiving services from a VAWA-funded shelter), the member touchpoints must be documented in a HMIS-comparable system, notwithstanding the services dictionary.
- **Billing for a household:** Tenancy providers cannot submit claims for Pre-tenancy or Tenancy Sustaining Services for multiple members of the same household. However, MCOs should give Tenancy Providers flexibility to define a household in specific cases concerning violence and safety issues (i.e., a victim of domestic violence should be considered a distinct household). Claims should be associated with a specific member who is a member of the household. The Tenancy Provider has discretion to decide which program eligible household member they submit a claim for. Provider guidance suggests but does not require that they bill for the head of the household.
- **No authorization past the first 30-days of services:** If Pre-tenancy or Tenancy Sustaining Services are not authorized past the 1st month (30-day period) of services, then the MCO must pay the claim for Pre-tenancy or Tenancy Sustaining Services at a PMPM rate associated with

the lower level of need for the 1st month (30-day period) of services, conditional on the provider delivering eligible services in that 1st month (30-day period).

- **Shortened billing periods:** In scenarios in which a billing period may be shortened (e.g., member changes providers, changes MCOs, or no longer participates in Medicaid), the MCO should pay the claim at the full amount if the touchpoint requirements are met within the shortened billing period. There will be no pro-ration of rates for Housing Supports.
- **Billing for a different level of need than authorized for:** Tenancy providers may not bill for a higher level of need than the member is authorized for. If there is a change in the member's need (e.g., due to a major life event), the provider should submit a reauthorization request (see **Section 7.E**). If a member is authorized for a lower level of need, and the Tenancy provider does not meet the touchpoint requirement in the billing period, they may not be paid for that billing period. If a member is authorized for a higher level of need, and the Tenancy provider delivers touchpoint requirements meeting a lower level of need (e.g., 2+ touchpoints), they may be paid at the rate for a lower level of need.
- **Credentialing requirements:** Providers may only be paid for Tenancy services if they are credentialed with the MCO as a Pre-tenancy or Tenancy Sustaining provider. This may not apply if the MCO has an established Single Case Agreement with the provider.

Payment for Residential Modifications and Remediation Services and **Move-in Supports** is structured as a cost-based reimbursement up to a lifetime cap, with an additional payment for evaluations or administration.

- There is a lifetime cap for Residential Modifications and Remediation Services. Members eligible or receiving MLTSS Residential Modifications and Remediation Services may not combine or add spending caps across programs or with their household members.
- There is a lifetime cap for Move-in Supports. Members eligible or receiving MLTSS Community Transition services may not combine or add spending caps across programs or with their household members.
- Providers may only be paid for Residential Modifications and Remediation Services if they are credentialed with the MCO as a Residential Modifications and Remediation Services provider. Providers may only be paid for Move-in Supports if they are credentialed with the MCO as either a Pre-tenancy / Tenancy Sustaining Services provider or Residential Modifications and Remediation Services provider. These may not apply if the MCO has an established Single Case Agreement with the provider.
- Residential Modifications and Remediation Services Providers and Tenancy Providers will submit an authorization request to spend a proposed amount on services. If authorized, the providers can spend this amount and be reimbursed by the MCO.
- Providers may also be paid for evaluation and administration services. These rates are set by the MCOs and not standardized by DMAHS.

For a touchpoint for Tenancy Services to qualify as **a valid touchpoint for claim submission**, the following requirements must be met:

- The touchpoint date must be within the billing period for claim submission.
- There is only one touchpoint for that day that counts forwards the minimum required touchpoints in a billing period in a claim submission
- At least half of the required minimum number of touchpoints for a level of need must be face-to-face with a member (i.e., for a low level of need member, 1 out of the minimum 2 touchpoints must be face-to-face).

- Face-to-face, telephone, email, text, or another electronic format is accepted for touchpoints that are not face-to-face with a member.
- The touchpoint must have occurred in a county in New Jersey.
- There must be one and only one service indicated for a touchpoint in a claim submission. Service options are:
    - Pre-tenancy Services "high" need
    - Pre-tenancy Services "low" need
    - Tenancy Sustaining Services "high" need
    - Tenancy Sustaining Services "low" need
- The touchpoint must be documented in HMIS based on requirements set forth by DMAHS. Touchpoints must be documented with all required fields and case notes completed, unless the member is protected (e.g., victims of domestic violence or intimate partner violence).
    - If a member's circumstances or provider's circumstances disallow the use of HMIS, the touchpoint must be documented in a HMIS-comparable system and stored locally subject to audit by DMAHS or the MCO.
    - DMAHS will provide further details on HMIS requirements.

These are the minimum requirements for a touchpoint, not the standard expectation of a touchpoint. Providers can and should meet with a member as needed to address their needs, in modalities that are appropriate and preferred by the member (e.g., telephonic, face-to-face, virtual). It is highly encouraged that providers document case notes that reflect the touchpoint activity that occurred.

Duplication of services:

A provider cannot get paid twice (in full or in part) for a service provided to an individual. Double billing or duplicative reimbursement for the same service is not permitted. See **Section 7.C.** for additional information on duplication of services.

If a claim is found to be inaccurate or duplicative, MCOs have the responsibility to review further and ask questions. If a resolution is not reached or if a provider is consistently under further review, the MCO reserves the right to disallow the provider from participating in the Housing Supports program. Providers who are found to have committed fraud are subject to consequences including but not limited to fines, restitution, exclusion from Medicaid/Medicare programs, revocation or suspension of licenses, and imprisonment[15].

B. Claims

MCOs must use the standardized billing codes described in **Section 15.C.** MCOs must pay claims to Housing Supports providers in a timely manner, as defined in the MCO contract.

C. Phone Line

MCOs are expected to have a toll-free phone line/queue to assist Housing Supports providers with claims processes. MCOs must provide scripts used to train phone line staff to DMAHS upon request (See **MCO contract).**

[15] https://oig.hhs.gov/compliance/physician-education/fraud-abuse-laws/

13. Quality and data reporting

A. Reporting and Templates

MCOs must submit reports of measures as defined by DMAHS using standardized reporting template(s).

14. Outreach Contacts

For questions or concerns related to the Housing Supports program, please contact:

Email: DMAHS.HousingSupports@dhs.nj.gov

Address:

New Jersey Department of Human Services (NJDHS)
Division of Medical Assistance and Health Services (DMAHS)
Office of Policy
PO BOX 712
Hamilton, NJ 08691

Website: https://www.nj.gov/humanservices/dmahs/home/

15. Appendix

A. Services Dictionary

Residential Modifications and Remediation Services
Physical modifications, adaptations, or remediation services to a beneficiary's private, primary residence required by their plan of care which are necessary to ensure the health, welfare and safety of the member, or which enable the member to function with greater independence in the home or community.

Modifications can include: the installation of ramps and grab bars, widening of doorways, modifications of bathrooms, the installation of accessibility ramps, the installation of wheelchair-level counters with cutouts for the sink, special mirrors and lighting accommodations for individuals with epilepsy, the installation of specialized electrical or plumbing systems that are necessary to accommodate the medical equipment and supplies which are needed for the health, safety and welfare of the individual.

Remediation Services can include: repairing or improving ventilation systems, and mold/pest remediation.

Heating and cooling services can include: medically necessary air conditioners, heaters, humidifiers, air filtration devices and other asthma remediation, and refrigeration units as needed for medical treatment.

Eligibility Criteria
- To access Residential Modifications and Remediation Services, members must meet eligibility criteria as detailed in Article 10.1.A of the New Jersey DMAHS MCO contract.
- Members are not eligible if they receive duplicative services through Medicaid or other federal, state, or locally-funded programs. This includes any program utilizing Medicaid funding such as MLTSS Residential Modifications and Remediation Services, or Home Modifications under the Division of Developmental Disabilities (DDD). Residential Modifications and Remediation Services shall supplement, but not supplant, other services received by the member.
- Members living in licensed residences (ALR, CPCH, ALP, and Class B & C Boarding Homes) are not eligible to receive Residential Modifications.

Service Limitations:
- Residential Modifications and Remediation Services are limited to $15,000 lifetime.
- Members eligible or receiving MLTSS Residential Modifications and Remediation Services may not combine or add spending caps across programs.
- Modifications to public areas of apartment buildings, communities governed by a homeowner association or community trust, and/or rental properties are the responsibility of the owner/landlord, association, or trust and excluded from this benefit.
- Residential Modifications may not be furnished to adapt living arrangements that are owned or leased by providers of waiver services.
- Excluded from this service are those modifications to the home that are of general utility and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, or central air conditioning.
- Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).

- All services shall be provided in accordance with applicable State/local building codes.
- If it is determined that one of the above limitations would prevent the MCO from implementing a more appropriate or cost-effective method of support or ensuring the health, safety and wellbeing of an individual, the MCO may exceed these limitations in those specific circumstances. The need to exceed the limitation must be documented in their care plan.
- The modifications and remediation cannot supplant a landlord's obligation to provide reasonable accommodations under the ADA.

Approval Requirements:
- For a home that is not owned by the member, modifications and adaptations require a written approval letter from the property owner and must include acknowledgement that the State/MCO is not responsible for the removal of the modification from the property.
- The member must assure continued tenancy for at least one year before the request can be approved
- Before commencement of the modification or remediation service, the MCO must provide the owner and beneficiary with written documentation that the modifications are permanent and that the State is not responsible for removal of any modification if the member ceases to reside at the residence.
- Approval of Residential Modifications and Remediation Services is based on identified need as indicated in the MCO care plan, or otherwise determined by the MCO. The adaptation will represent the most cost-effective means to meet the needs of the member.

Provider Specifications:
- The provider must be approved and credentialed by the member's MCO.
- The provider must demonstrate ability to comply with Medicaid systems including, but not limited to, billing and invoicing, data reporting, and any additional Medicaid systems required to provide housing services.
- The provider must be licensed in New Jersey per the Division of Consumer Affairs, NJSA 56:8-136 et seq. as a home repair contractor.
- Licensed provider organizations with valid business registration with the Department of Community of Affairs include but are not limited to:
    - HVAC contractors
    - Construction contractors
    - Mold Removal and Remediation
    - Pest remediation

Billing Specifications:

Billing Code:
- Modifications: S5165_U2
- Remediations: S5165_U3
- Evaluations: T1028

Unit of Service: Per Occurrence
Licensing Entity: NJ Department of Law and Public Safety, Division of Consumer Affairs
Accredited by:
Regulation Cites: NJAC 5:23-2, NJSA 56:8-136 et seq., NJAC 5:17
Taxonomy Code:

Move-in Supports

Payment for non-recurring, one-time transitional expenses provided to a beneficiary during the transition period to their own home, including:

- Payment for the set-up of the new housing unit, to address needs identified in the person-centered care plan.
    - Services required for a beneficiary's health and safety, such as pest eradication and one-time cleaning prior to move-in.
    - Purchase of household furnishings needed to establish community-based tenancy including furniture, food preparation items, pantry stocking, or bed/bath linens. If necessary, assistance may also be provided to help set up these items.

- Payment for items to support the details of the move, as appropriate, including:
    - Costs for filing applications and payment of application fees necessary to obtain a lease on a home.
    - Payment for move-in costs including movers to ensure transportation of self and possessions to new housing arrangement.
    - Payment of security deposits.
    - Payment of set-up fees or deposits for utility or service access, including telephone, electricity, heating and water.

Eligibility Criteria:

- To access Move-in Supports, members must meet eligibility criteria as detailed in Article 10.1.A of the New Jersey DMAHS MCO contract.
- Members are not eligible if they receive duplicative services through Medicaid or other federal, state, or locally-funded programs, including MLTSS Community Transition Services, Community Supports Services (CSS), and Integrated Case Management Services (ICMS). Move-in Supports shall supplement, but not supplant other services received by the member.

Service Limitations:

- Move-in Supports are limited to $10,000 lifetime.
- Move-in Supports are limited to one 'moving experience' per lifetime per member
- Members eligible or receiving MLTSS Community Transition services may not combine or add spending caps across programs.
- Move-in Supports do not include residential or vehicle modifications.
- Move-in Supports do not include recreational items such as televisions, cable television access or video players.
- Move-in Supports do not include pre-owned items that may be physically unsafe for the member, such as used mattresses.
- Move-in Supports cannot be used to support moves into institutions (e.g., nursing facilities).
- Move-in Supports do not include recurring expenses such as weekly groceries and regular utility charges.
- Payment for security deposit is not considered rent.
- Move-in Supports do not include monthly rental or mortgage expenses.
- Move-in Supports are furnished only to the extent that they are reasonable and necessary as determined through the care plan development process or otherwise approved by the MCO, clearly identified in the service plan, and the person is unable to meet such expense or the services cannot be obtained from other sources.

Approval Requirements:

- Approval of Move-in Supports is based on identified need as indicated in the individualized housing stabilization plan or MCO care plan. Services can be accessed up to 90 days prior to transition as part of member's transition plan.

Provider Specifications:

- Services may be paid for directly (e.g., direct payment to the landlord) or subcontracted by Pre-tenancy or Tenancy Sustaining Service Provider, or by the MCO.
- Services may be provided by eligible Residential Modifications and Remediation Services providers.

Billing Specifications:

Billing Codes:

- T2038_U1
- Administration: T2038_U6

Unit of Service: As negotiated per the MCO.
Licensing Entity:
Accredited by:
Regulation Cites:
Taxonomy Code:

Pre-tenancy Services

Services that support beneficiaries in obtaining housing, including but not limited to:

- Developing an individualized housing support plan. The plan should establish short and long-term measurable goals, describing how goals will be achieved and how barriers will be addressed. The plan should also include prevention and early intervention services if housing is jeopardized. An example of a housing support plan may include:
    - For individuals exiting institutions (e.g., nursing facilities), thorough and proactive discharge planning and other transitionary tasks.

- Assisting with navigating the complexities of the housing application process through the progression of prospective tenant to tenant as well as assisting with the housing search.
    - Searching for housing, presenting options to the beneficiary, and contacting prospective housing options for availability and information.
    - Facilitating enrollment in the local Continuum of Care's Coordinated Entry System or in the school's McKinney-Vento program.
    - Assisting the beneficiary in undergoing tenant screening.
    - Completing rental applications.
    - Assisting the beneficiary to communicate with the landlord or property manager, including accompanying the head of household to appointments, lease negotiations, and signings.
    - Review of the living environment to ensure it is safe and ready for move-in.
    - Assisting in arranging for and supporting the details of the move.

- Identifying, coordinating, and securing resources to assist with housing costs and other expenses.
    - Assisting in obtaining required documentation (e.g., Social Security card, birth certificate, income and benefits statements, prior rental history) for housing assistance programs and applications or any social service program, as needed to transition to tenancy.
    - Helping complete applications and navigating the process to obtain financial supports to afford housing, including linkages to rental assistance, security deposits, application fees, moving costs, non-medical transportation to tour units and attend tenant interviews, and food and clothing needed at transition.
    - Providing financial education including credit repair and credit counseling, 1:1 budgeting assistance, assistance with setting up a bank account, and bill paying.
    - Identifying and connecting the beneficiary to resources that promote long-term housing stability, including mental health resources, affordable childcare, employment, transportation, and school enrollment.
    - Identifying and making referrals to legal services to address complex tenancy issues preventing an individual from entering a housing arrangement.

Eligibility Criteria:

- To access Pre-tenancy Services, members must meet eligibility criteria as detailed in Article 10.1.A of the New Jersey DMAHS MCO contract.
- Eligible members will be assessed and categorized as higher or lower level of need using a standardized tool developed by New Jersey DMAHS.
- Members are not eligible if they receive duplicative services through Medicaid or other federal, state, or locally-funded programs, including Community Supports Services (CSS) and Integrated Case Management Services (ICMS). Pre-tenancy Services shall supplement, but not supplant other services received by the member.

Required engagement:

- Providers must deliver 2 touchpoints per month (30-day billing period) for low level of need members, and 4 touchpoints for high level of need members. Touchpoints are defined as delivering

activities consistent with the definition in Guidance on separate days within a month (30-day billing period).
- Providers must document touchpoints in New Jersey's Homeless Management Information System (HMIS) or a HMIS-comparable system consistent with additional guidance from DMAHS.

Service Limitations:
- Members are not eligible if they receive duplicative services through Medicaid or other federal, state, or locally-funded programs. Pre-tenancy Services shall supplement, but not supplant services received by the member.
- Members are not eligible for Pre-tenancy Services while receiving Housing Supports Tenancy Sustaining Services.
- Duration will persist until service no longer needed, with eligibility and needs reassessed every 6 months. On average, 6-18 months of Pre-tenancy Services and Tenancy Sustaining Services may be needed to become stably housed, but individual needs will vary and may continue beyond the 18-month timeframe.

Provider specifications:
- Must demonstrate ability to comply with Medicaid systems including but not limited to billing and invoicing, data reporting, and any additional Medicaid systems required to provide housing services.
- Provider organizations must have prior experience and expertise delivering comparable services. Examples of prior experience include but are not limited to CoC funded organizations who provide emergency shelter services, transitional housing, permanent supportive housing, rapid rehousing, or safe haven services; as well organizations that provide PATH (Projects for Assistance in Transition from Homelessness) services (funded by the Substance Abuse and Mental Health Services Administration), Integrated Case Management Services (funded by New Jersey Department of Mental Health and Addiction Services), or Comprehensive Eviction Defense & Diversion services (funded by New Jersey Department of Community Affairs). DMAHS will provide additional details in the Housing Supports Guidance document.
- Provider organizations must utilize New Jersey's Homeless Management Information System (HMIS) or a HMIS-comparable system consistent with additional guidance from DMAHS.
- Provider organizations must demonstrate cultural competency, trauma-informed care, and adequate resources to address the needs of a diverse population (e.g., bilingual staff, staff with lived experience, or plans to contract with vendors with such staff).

Billing Specifications:

Billing Codes:
- Low level of need: H0044_U1
- High level of need: H0044_U3

Unit of Service: Per member per 30 days
Licensing Entity:
Accredited by:
Regulation Cites:
Taxonomy Code:

Tenancy Sustaining Services

Services that support beneficiaries achieve their goal of maintaining safe and stable tenancy, including but not limited to:

- Developing or revisiting an individualized housing support plan. The plan should establish short and long-term measurable goals, describing how goals will be achieved and how barriers will be addressed.
- Assisting with the housing recertification processes, including lease renewals and housing subsidy renewals.
- Educating and training the beneficiary on the role, rights and responsibilities of the tenant and landlord.
- Supporting the beneficiary in development of independent living and tenancy skills, including: housekeeping; cleanliness; time management; financial literacy skills; budgeting; fraud prevention; establishing a bank account; connections to community services including grocery stores, transportation, schools, and jobs; as well as connecting the individual to social services based on additional needs as identified in the housing support plan. Connections to social services can include programs and services for employment, education, health, food (e.g., SNAP), legal services, eviction prevention, or other social services
- Identifying and helping secure benefits or supports to help pay for rent and utilities, including assistance filling out applications and gathering appropriate documentation in order to obtain sources of income necessary for community living (e.g., Social Security, HUD Housing Choice Vouchers, etc.).
- Providing assistance in addressing circumstances or behaviors that may jeopardize housing such as late payment, lease violation, maintenance issues, disputes with landlords or neighbors, or other identified issues. This should include both direct interventions to address risks and connection of the beneficiary to relevant community resources that may offer assistance with those risks.

Eligibility Criteria:

- To access Tenancy Services, members must meet eligibility criteria as detailed in Article 10.1.A of the New Jersey DMAHS MCO contract.
- Eligible members will be assessed and categorized as higher or lower level of need using a standardized tool developed by New Jersey DMAHS.
- Members are not eligible if they receive duplicative services through Medicaid or other federal, state, or locally-funded programs, including Community Supports Services (CSS) and Integrated Case Management Services (ICMS). Tenancy Sustaining Services shall supplement, but not supplant other services received by the member.

Required engagement:

- Providers must deliver 2 touchpoints per month (30-day billing period) for low level of need members, and 4 touchpoints per month for high level of need members. Touchpoints are defined as delivering activities consistent with the definition in Guidance on separate days within a month (30-day billing period).
- Providers must document touchpoints in New Jersey's Homeless Management Information System (HMIS) or a HMIS-comparable system, consistent with additional guidance from DMAHS.

Service Limitations:

- Members are not eligible if they receive duplicative services through Medicaid or other federal, state, or locally-funded programs. Tenancy Sustaining Services shall supplement, but not supplant services received by the member.

- Members are not eligible for Tenancy Sustaining Services while receiving Housing Supports Pre-tenancy Services.
- Duration will persist until service no longer needed, with eligibility and needs reassessed every 6 months. On average, 6-18 months of Pre-tenancy and Tenancy Sustaining Services may be needed expected to become stably housed but individual needs will vary and may continue beyond the 18-month timeframe.
- Tenancy Sustaining Services do not include monthly rental or mortgage expenses.

Provider specifications:
- Must demonstrate ability to comply with Medicaid systems including but not limited to billing and invoicing, data reporting, and any additional Medicaid systems required to provide housing services.
- Provider organizations must have prior experience and expertise delivering comparable services. Examples of prior experience include but are not limited to CoC funded organizations who provide emergency shelter services, transitional housing, permanent supportive housing, rapid rehousing, or safe haven services; as well organizations that provide PATH (Projects for Assistance in Transition from Homelessness) services (funded by the Substance Abuse and Mental Health Services Administration), Integrated Case Management Services (funded by New Jersey Department of Mental Health and Addiction Services), or Comprehensive Eviction Defense & Diversion services (funded by New Jersey Department of Community Affairs).
- Provider organizations must utilize New Jersey's Homeless Management Information System (HMIS) or a HMIS-comparable system, consistent with additional guidance from DMAHS.
- Provider organizations must demonstrate cultural competency, trauma-informed care, and adequate resources to address the needs of a diverse population (e.g., bilingual staff, staff with lived experience, or plans to contract with vendors with such staff)

Billing Specifications:

Billing Codes:
- Low level of need: H0044_U4
- High level of need: H0044_U6

Unit of Service: Per member per 30 days
Accredited by:
Regulation Cites:
Taxonomy Code:

B. HRSN Services Protocol (Selected Excerpts)

See linked here for the full HRSN Services Protocol

HRSN Services including housing supports, nutrition supports, and medically indicated meals. In accordance with the state's Section 1115 Demonstration and Special Terms and Conditions (STCs), this protocol provides additional detail on the requirements for the delivery of services for the Health-Related Social Needs (HRSN) Services including housing supports, nutritional supports, and medically indicated meals, as required by STC 10.6. New Jersey may claim Federal Financial Participation (FFP) for the specified evidence-based HRSN services identified in STC 10.2 (subject to the restrictions

described below and the exclusions in STC 10.4). This protocol outlines the (I) social risk and clinical risk factor eligibility criteria, (II) covered HRSN services, (III) provider qualifications requirements, (IV) processes for identifying and screening eligible individuals, (V) processes for determining eligibility and authorizing services, (VI) care management and planning requirements, and (VII) processes to avoid conflicts of interests. The HRSN services (duration, scope, and definitions) are subject to the restrictions described below.

II. Beneficiary Eligibility.

a. Housing Supports

i. **Covered Population**. Currently enrolled MCO Medicaid beneficiaries will be eligible to receive housing supports services provided that they also satisfy the applicable clinical and social risk criteria.

ii. **Clinical Risk Factors**. Individuals who meet one or more of the clinical-based criteria defined in Appendix Table 1.

iii. **Social Risk Factors.** Individuals must also meet one or more of the social risk factor criteria defined in Appendix Table 2.

III. HRSN Services

a. **Nonduplication of services.** No HRSN service will be covered that is found to be duplicative of a state, federally, or locally funded service or other HRSN service the beneficiary is already receiving.

b. **Providing culturally and linguistically appropriate services.** To the fullest extent possible, all HRSN services must be provided in a way that is culturally responsive and ensures meaningful access to language services. MCOs and their contracted providers must ensure that the HRSN services follow all existing contract requirements defined in the New Jersey DMAHS for the delivery of culturally responsive services, screening, education and care planning.

c. **Covered HRSN Services.** The state will cover the following HRSN services as defined below:

Program	Service	Description
Housing Supports	Pre-tenancy Services	Services that support beneficiaries in obtaining housing, including but not limited to: • Developing an individualized housing support plan. The plan should establish short and long-term measurable goals, describing how goals will be achieved and how barriers will be addressed. The plan should also include prevention and early intervention services if housing is jeopardized. An example of a housing support plan may include: ○ For individuals exiting institutions (e.g., nursing facilities), thorough and proactive discharge planning and other transitionary tasks. • Assisting with navigating the complexities of the housing application process through the progression of prospective tenant to tenant as well as assisting with

		the housing search ○ Searching for housing, presenting options to the beneficiary, and contacting prospective housing options for availability and information. ○ Facilitating enrollment in the local Continuum of Care's Coordinated Entry System or in the school's McKinney-Vento program. ○ Assisting the beneficiary in undergoing tenant screening. ○ Completing rental applications. ○ Assisting the beneficiary to communicate with the landlord or property manager, including accompanying the head of household to appointments, lease negotiations, and signings. ○ Review of the living environment to ensure it is safe and ready for move- in. • Assisting in arranging for and supporting the details of the move. Identifying, coordinating, and securing resources to assist with housing costs and other expenses ○ Assisting in obtaining required documentation (e.g., Social Security card, birth certificate, income and benefits statements, prior rental history) for housing assistance programs and applications or any social service program, as needed to transition to tenancy. ○ Helping complete applications and navigating the process to obtain financial supports to afford housing, including linkages to rental assistance, security deposits, application fees, moving costs, non- medical transportation to tour units and attend tenant interviews, and food and clothing needed at transition. ○ Providing financial education including credit repair and credit counseling, 1:1 budgeting assistance, assistance with setting up a bank account, and bill paying. ○ Identifying and connecting the beneficiary to resources that promote long-term housing stability, including mental health resources, affordable childcare, employment, transportation, and school enrollment ○ Identifying and making referrals to legal services to address complex tenancy issues preventing a individual from entering a housing arrangement
Housing Supports	Tenancy Sustaining Services	Services that support beneficiaries achieve their goal of maintaining safe and stable tenancy, including but not limited to:

		• Developing or revising an individualized housing support plan. The plan should establish short and long-term measurable goals, describing how goals will be achieved and how barriers will be addressed. • Assisting with the housing recertification processes, including lease renewals and housing subsidy renewals. • Educating and training the beneficiary on the role, rights and responsibilities of the tenant and landlord. • Supporting the beneficiary in development of independent living and tenancy skills, including: housekeeping; cleanliness; time management; financial literacy skills; budgeting; fraud prevention; establishing a bank account; connections to community services including grocery stores, transportation, schools, and jobs; as well as connecting the individual to social services based on additional needs as identified in the housing support plan. Connections to social services can include programs and services for employment, education, health, food (e.g., SNAP), legal services, eviction prevention, or other social services • Identifying and helping secure benefits or supports to help pay for rent and utilities, including assistance filling out applications and gathering appropriate documentation in order to obtain sources of income necessary for community living (e.g., Social Security, HUD Housing Choice Vouchers, etc.). Providing assistance in addressing circumstances or behaviors that may jeopardize housing such as late payment, lease violation, maintenance issues, disputes with landlords or neighbors, or other identified issues. This should include both direct interventions to address risks and connection of the beneficiary to relevant community resources that may offer assistance with those risks.
Housing Supports	Move-in Supports	• Payment for non-recurring, one-time transitional expenses provided to a beneficiary during the transition period to their own home., including: Payment for the set-up of the new housing unit, to address needs identified in the person-centered care plan ○ Services required for a beneficiary's health and safety, such as pest eradication and one-time cleaning prior to move-in ○ Purchase of household furnishings needed to establish community-based tenancy including furniture, food preparation items, pantry

		stocking, or bed/bath linens. If necessary, assistance may also be provided to help set up these items
		• Payment for items to support the details of the move, as appropriate, including:
		  ○ Costs for filing applications and payment of application fees
		  ○ Payment for move-in costs including movers to ensure transportation of self and possessions to new housing arrangement
		  ○ Payment of security deposits
		  ○ Payment of set-up fees or deposits for utility or service access, including telephone, electricity, heating and water

Housing Supports	Residential Modifications and Remediation Services	Physical modifications, adaptations, or remediation services to a beneficiary's private primary residence required by their care plan which are necessary to ensure the health, welfare and safety of the beneficiary, or which enable the beneficiary to function with greater independence in the home or community. • Modifications can include: the installation of ramps and grab bars, widening of doorways, modifications of bathrooms, the installation of accessibility ramps, the installation of wheelchair-level counters with cutouts for the sink, special mirrors and lighting accommodations for individuals with epilepsy, the installation of specialized electrical or plumbing systems that are necessary to accommodate the medical equipment and supplies which are needed for the health, safety and welfare of the individual. • Remediation services can include: repairing or improving ventilation systems, and mold/pest remediation. • Heating and cooling services can include: Medically necessary air conditioners, heaters, humidifiers, air filtration devices and other asthma remediation, and refrigeration units as needed for medical treatment.

IV. Provider Qualifications

a. **Housing Supports** providers will be required to meet the following minimum qualification requirements for the service(s) they are providing. DMAHS will provide additional guidance on how organizations can demonstrate compliance with these qualifications.

i. Pre-tenancy and Tenancy Sustaining Service providers must have knowledge of principles, methods, and procedures of housing services covered under the waiver or have experience providing comparable services meant to support individuals in obtaining and maintaining stable housing
ii. Medically necessary home modification and remediation services and devices providers must have the ability to timely and appropriately deliver services to beneficiaries' homes
iii. Move-in Supports providers must have the ability to timely and appropriately deliver services to beneficiaries' homes

V. Beneficiary Identification and Assessment of Service Need

a. **Identification**.
   i. **Housing Supports**. MCOs will ensure multiple pathways to identify and engage MCO Medicaid beneficiaries who potentially have one or more housing supports service needs. Pathways for beneficiary identification must include:
      1. MCOs proactively identifying and engaging beneficiaries through a review of encounter and claims data
      2. MCOs accepting self-referrals from the beneficiary or their family/caregivers
      3. MCO care managers identifying beneficiaries through ongoing engagement including through transition planning processes for individuals transitioning from institutional settings to the community
      4. MCO accepting referrals from the MCO's health care provider network
      5. MCOs accepting referrals from county social service agencies and organizations that connect or enroll individuals in other housing-related assistance programs (i.e., Continuum of Care, Public Housing Authorities, etc.)
      6. MCO accepting referrals from community-based providers, agencies or organizations who offer housing support services and/or engage beneficiaries who may have housing support needs, which could include:
         a. Private and public housing service agencies and housing supports providers (e.g., homeless shelters, permanent supportive housing organizations)
         b. Correctional institutions
         c. Other CBOs who engage MCO Medicaid beneficiaries

b. **Assessment of Service Need**.
   i. **Housing Supports**. MCOs will collect necessary information about beneficiaries identified with a housing support service need for an approval decision. MCOs will collect this information through multiple pathways, including through referrals for services sent to MCOs, as described above, and through MCO care managers identifying beneficiaries' needs through ongoing engagement.
   ii. **MLTSS Nutrition Supports.** MCOs will collect necessary information about

Medicaid MLTSS beneficiaries identified with a nutrition support service need for an approval decision through service referrals as described above. In addition, DMAHS will integrate nutritional need screening into existing MLTSS care planning requirements by updating the Plan of Care and Community Transition plan development criteria specified in the New Jersey DMAHS *MCO Contract Article* 9.6.4. The Care Manager shall screen MLTSS beneficiaries for nutritional need, review each service to ensure that the frequency, duration, or scope of the services accurately reflects the beneficiary's current need, and update the plan of care to document the need and use of the approved service as necessary. Assessment of food security status may be determined by methods such as but not limited to USDA's Food Security Survey Modules or a method developed by DMAHS.

iii. **Medically Indicated Meals Pilot.** The Medically Indicated Meals Pilot will be conducted with selected MCOs. Additional details on beneficiary identification will be determined in collaboration with MCO(s) upon selection of MCO(s) for the pilot. At minimum, MCO(s) must screen for eligibility based on clinical and HRSN risk factors using data sources that include, but are not limited to: encounter and claims data, NJ's Perinatal Risk Assessment, and MCO's obstetrical care management activities. In the case of self-referral or direct referral, or when other data sources for screening information are not available, MCO(s) may accept a clinical referral as long as it is documented. Assessment of food security status may be determined by methods such as but not limited to USDA's Food Security Survey Modules or a method developed by DMAHS.

VI. Eligibility Determination and Services Approval

a. **Housing Supports.**

i. MCOs will utilize their existing infrastructure and process for the service authorizations and reauthorizations.

ii. Upon receipt of the information regarding the beneficiary's housing needs, the MCO will use reasonable efforts to obtain all other information necessary to 1) determine whether the beneficiary is eligible for housing support and 2) to authorize the appropriate services. The MCO's reasonable efforts must include:

1. Obtaining the results from housing need screening questions to assess eligibility to receive housing supports services
2. Collecting beneficiary information from the beneficiary's transition or care plan, or from the plan's own beneficiary records
3. Collecting relevant and appropriate information obtained via follow up with the beneficiary or referring organization/individual if necessary

iii. Service approval, including amount, duration, and scope of services, will be based on the following criteria:

1. Confirmation that the beneficiary is enrolled in the MCO
2. Determination that the beneficiary meets at least one social and clinical risk factor eligibility criteria for at least one of the housing supports services
3. Assessment of the beneficiary's clinical and social needs that justify the medical appropriateness of the service

iv. MCOs will expeditiously notify the beneficiary of authorization for the housing support services; and provide information about appeals and hearing rights.
v. MCOs will communicate the approval or denial of services to the individual.
vi. MCOs will communicate the approval or denial of services to the referring organization, where appropriate and with the beneficiary's consent, to create a closed loop referral. MCOs must have processes in place to rescreen and reauthorize beneficiaries receiving housing support services every 12 months, or after a change in housing conditions.

VII. Care Plan Development Process

a. **Housing Supports**. MCOs will leverage and significantly expand their existing housing infrastructure and process for care planning for beneficiaries to ensure the needs of the member are met.
    i. The MCO will offer care management for beneficiary approved for housing support services. The care management will include:
        1. Developing a care plan with the beneficiary, with review at least every 12 months; MCO Housing Specialists will utilize their housing expertise to help develop appropriate care plans for members.
        2. Referring the beneficiary to an HRSN provider for the approved services, and supporting beneficiary choice of provider, ensuring beneficiary needs are met by the Provider in a timely manner, including through regular communication with the individual and HRSN Provider delivering the service, and finding alternative providers if needed;
        3. Identifying other HRSN services the beneficiary may need;
        4. Determining what other services the beneficiary is receiving or may be eligible to receive under Medicaid or other programs;
        5. Coordinating with other social support services and care management the beneficiary is already receiving or becomes eligible for while receiving the HRSN service;
        6. Conducting reassessment for services prior to the conclusion of the service; and
        7. At a minimum, conducting a 6-month check-in to understand if HRSN services are meeting their needs, if additional/new services are needed if the service duration is longer than 6 months, or if HRSN services are duplicating other services they are receiving.
    ii. The MCO will create the care plan with the beneficiary to obtain the HRSN service as approved by the MCO. The MCO will gather input from the MCO Housing Specialist and relevant organizations that have a trusted existing relationship with the beneficiary, including the organization that referred the beneficiary for services or is currently delivering services to the beneficiary. The care plan will be in writing and developed with and agreed upon by the beneficiary.
        1. The care plan will include:
            a. The recommended HRSN service;

b. The service duration;
c. The determination that the recommended service, unit of service, and service duration is medically appropriate based on clinical and social risk factors;
d. The goals of the service(s);
e. The follow-up and transition plan;
f. The MCO care management team responsible for managing the beneficiary's HRSN services.

iii. Care management must include at least one meeting with the beneficiary, either in person or by telephone or videoconference during the development of the care plan. If efforts to have a meeting are unsuccessful, the MCO is required to document connection attempts, barriers to having a meeting, and justification for continued provision of service.
iv. Beneficiaries may choose to initiate services, consistent with their Services Approval, prior to the completion of the care plan documentation process.

VIII. Conflict of Interest

a. To protect against conflict of interest and ensure compliance with HCBS conflict of interest standards, the state will require that the MCOs perform the service authorization function and develop the care plan, and prohibit the subcontracting of such functions where that would result in a single entity conducting the service authorization, care planning, and service provision, except as provided in subsection (b) below, or otherwise approved by DMAHS.
b. Service authorization, care planning, and service provision for select services may be provided by the MCO, subject to protocols established by the state to ensure that service authorization, care planning, and service provision are performed in a manner that guards against conflicts of interest and ensures that beneficiaries receive counseling and education on provider and services options in accordance with all applicable requirements.

HRSN Appendix

Table 1. Housing Supports Clinical Risk Factor Criteria

Clinical-Based Criteria	Description
Chronic health condition	One or more chronic conditions consistent with those identified in Social Security Act section 1945(h)(2). Examples of conditions can include: diabetes, BMI over 25, cardiovascular disease, respiratory disease, HIV/AIDS diagnosis, hypertension, physical disability (e.g. amputation, visual impairment), cancer, hyperlipidemia, chronic obstructive pulmonary diseases, chronic kidney disease
Mental health condition	An individual with at least one serious mental health illness, consistent with conditions included in the definition in N.J.A.C. 10:37B and/or at least two concurrent mental health conditions that require support and are impacting the ability to maintain a stable housing situation. Applicable mental health conditions include but are not limited to: Bipolar Disorder; Borderline Personality Disorder; Depression; Dissociative Disorders; Eating Disorders; Obsessive-compulsive Disorder Posttraumatic Stress Disorder; Psychosis Schizoaffective Disorder; and Schizophrenia.
Substance misuse	An individual with a substance use disorder who is in need of substance use treatment.
Pregnancy	Identified as: I. An individual who is currently pregnant II. An individual who is up to 12 months after the end of pregnancy.
Complex medical health condition caused by an intellectual or developmental disability	Qualifying physical, neurological, or behavioral, condition that directly impacts the ability to maintain a healthy and stable lifestyle.
Individuals experiencing intimate partner violence, domestic violence, and/or victims of human trafficking	An individual who is experiencing or has experienced intimate partner violence (IPV), domestic violence, or human trafficking.

Assistance with ADLs and IADLS	Individual assessed to have a need for assistance with: I. 1 or more activity of daily living (ADL), or II. 3 or more instrumental activities of daily living (IADL) and has a behavioral health condition or cognitive

	impairment (e.g., impairment to decision making or memory).
Repeated emergency department use or hospital admissions	An individual with repeated use of emergency department care (defined as two or more visits in the past 6 months or four or more visits in the past 12 months).

Table 2. Housing Supports Social Risk Factor Criteria

Social-Risk Criteria	Description
Currently experiencing homelessness	Meets any of the 4 categories of "homeless" established by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5: 1. Literally Homeless 2. Imminent Risk of Homelessness 3. Homeless Under Other Federal Regulations 4. Fleeing/Attempting to Flee Domestic Violence
At risk of homelessness	Meets any of the categories of "at risk of homelessness" detailed in Section (1)(iii), (2), or (3) of the definition, established by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5.
Individuals at risk of institutionalization who require a new housing arrangement to remain in the community	Qualifying institutions include: hospitals, mental health residential treatment facilities, substance use disorder treatment facilities, and long-term care facilities.
Transitioning from an institution to the community	This includes beneficiaries who could potentially transition from an institution to the community but are unable due to insufficient placement options. Qualifying institutions include: hospitals, mental health residential treatment facilities, substance use disorder treatment facilities, and long-term care facilities.
Individuals released from correctional facilities	Includes beneficiaries released from incarceration within the past 12 months. Qualifying institutions include: state and federal prisons, local correctional facilities, and juvenile detention facilities.

New Jersey 1115 HRSN Services Matrix: Housing

Service	Eligible Population	Social Risk Factor	Clinical Criteria for the pop
Pre-tenancy services	MCO enrolled members	- Currently experiencing homelessness - At risk of homelessness - Individuals at risk of institutionalization who require a new housing arrangement to remain in the community - Transitioning from an institution to the community - Individuals released from correctional facilities	- Chronic health condition - Mental health condition - Substance misuse - Pregnancy - Complex medical health condition caused by an intellectual or developmental disability - Individuals experiencing intimate partner violence, domestic violence, and/or victims of human trafficking - Assistance with ADLs and IADLS - Repeated emergency department use or hospital admissions
Tenancy sustaining services	MCO enrolled members	- Currently experiencing homelessness - At risk of homelessness - Individuals at risk of institutionalization who require a new housing arrangement to remain in the community - Transitioning from an institution to the community - Individuals released from correctional facilities	- Chronic health condition - Mental health condition - Substance misuse - Pregnancy - Complex medical health condition caused by an intellectual or developmental disability - Individuals experiencing intimate partner violence, domestic violence, and/or victims of human trafficking - Assistance with ADLs and IADLS - Repeated emergency department use or hospital admissions
Move-in Supports	MCO enrolled members	- Currently experiencing homelessness - At risk of homelessness - Individuals at risk of institutionalization who require a new housing arrangement to remain in the community - Transitioning from an institution to the community - Individuals released from correctional facilities	- Chronic health condition - Mental health condition - Substance misuse - Pregnancy - Complex medical health condition caused by an intellectual or developmental disability - Individuals experiencing intimate partner violence, domestic violence, and/or victims of human trafficking - Assistance with ADLs and IADLS - Repeated emergency department use or hospital admissions
Residential Modifications and Remediation Services	MCO enrolled members	- Currently experiencing homelessness - At risk of homelessness - Individuals at risk of institutionalization who require a new housing arrangement to remain in the community - Transitioning from an institution to the community - Individuals released from correctional facilities	- Chronic health condition - Mental health condition - Substance misuse - Pregnancy - Complex medical health condition caused by an intellectual or developmental disability - Individuals experiencing intimate partner violence, domestic violence, and/or victims of human trafficking - Assistance with ADLs and IADLS - Repeated emergency department use or hospital admissions

C. Payment Amounts

Payment amounts are provisional and still subject to change.

Service	Rate Structure	HCPCS Code	Service specification	Modifier	Rate Amount
Pre-tenancy Services	Once per member per 30-day billing period	H0044	Lower level of need	U1	$320
			Higher level of need	U3	$640
Tenancy Sustaining Services	Once per member per 30-day billing period	H0044	Lower level of need	U4	$320
			Higher level of need	U6	$640
Move-in Supports	Cost-based reimbursement up to a cap	T2038		U1	$10,000 cap per member lifetime
	Payment for administration	T2038		U6	MCO determined rates
Residential Modifications and Remediation Services	Cost-based reimbursement up to a cap	S5165	Residential Modifications	U2	$15,000 cap per member lifetime
			Remediation Services	U3	
	Payment for evaluation	T1028		No modifier	MCO determined rates

Exhibit 10. Payment amounts for Housing Supports services

D. Billing Codes

Service	Rate Structure	HCPCS Code	Service specification	Modifier	Code status
Pre-tenancy Services	Once per member per 30-day billing period	H0044	Lower level of need	U1	New
			Reserve	U2	New
			Higher level of need	U3	New
Tenancy Sustaining Services	Once per member per 30-day billing period	H0044	Lower level of need	U4	New
			Reserve	U5	New
			Higher level of need	U6	New
Move-in Supports	Cost-based reimbursement up to a cap	T2038	MLTSS Community Transition	No modifier	Existing
			Move-in Supports	U1	New
	Payment for administration	T2038	MLTSS Community Transition and Move-in Supports	U6	Existing
Residential Modifications and Remediation Services	Cost-based reimbursement up to a cap	S5165	MLTSS Modifications	No modifier	Existing
			Housing Supports Modifications	U2	New
			Housing Supports Remediation Services	U3	New
	Payment for evaluation	T1028	MLTSS and Housing Supports	No modifier	Existing

Exhibit 11. Billing codes for Housing Supports services.

E. Care Management Workbook

NJ FamilyCare Care Management Workbook details guidance for MCO care management.

16. Tools and Templates

Note that tools and templates are published as separate documents for ease of use and linked below.

Tool/Template	Where to find resource
Credentialing Application for Pre-Tenancy and Tenancy Sustaining Services	Credentialing Application linked here
Initial Assessment Tool	Initial Assessment Tool linked here
Level of Need Assessment	Level of Need Assessment linked here
Housing Stabilization Plan	Housing Stabilization Plan linked here
Housing Stabilization Plan Rubric	MCOs should ensure that all areas of the 'Housing Stabilization Plan' are filled out including at least 1 goal and action for each of the 3 plan components (i.e., housing, health, income) as well as ensuring that the plan has all necessary signatures and responses to questions. In the case that a plan does not have the required minimum level of completeness, the MCO may request a resubmission of the plan by the provider or deny authorization according to guidance for service authorization.
Non-evaluative Housing Stabilization Plan Rubric	The non-evaluative housing stabilization plan rubric is still in development. DMAHS will share a draft rubric with MCOs.

17. Update History

This document is the first public version of this guidance. As DMAHS publishes updated versions of this guidance, it will note major changes in this section.