Housing Stabilization Services

Remote Regional Roadshow for Counties and Tribes

Minnesota Department of Human Services Housing and Support Services Division
Roadshow Agenda

• High Level Overview of Housing Stabilization Services
• Role of County or Tribal Assessors and Case Managers
• Provider Training Updates
• Individual Enrollment Process (Eligibility Request Form)
• Managed Care Organizations
• Impact to Housing Support
• Important Reminders and Additional Resources
A new Medicaid benefit available as of July 20, 2020 to help people with disabilities and seniors find and keep housing.
Important News:

Housing Stabilization Services are now available for individual enrollment as of July 20, 2020

Due to the impacts of COVID-19 on the Housing Stabilization Services Eligibility Review System development:

• Claims and billing start date is expected to be August 24, 2020
Goals of the Services

- Support an individual's **transition** to housing
- Increase **long-term stability** in housing
- **Avoid** future periods of homelessness or institutionalization
Housing Stabilization Services

Transition

• Helps people **plan for, find and move** into housing

Sustaining

• **Supports a person to maintain** living in their home

**Housing Consultation**: A new planning service available through Housing Stabilization Services that provides a person-centered plan for people without Medicaid funded case management
Eligibility for Housing Stabilization Services

Medical Assistance recipient who is 18 years old or older

Disability or disabling condition + Housing instability + Need for services due to limitations caused by the individual's disability
Disability/Disabling Condition

• Aged, blind, or disabled as described under Title II of the Social Security Act (SSI/SSDI)

• People determined by a medical professional to have any the following conditions:
  • Long-term injury or illness
  • Mental illness
  • Developmental disability
  • Learning disability
  • Substance use disorder

• Proof of disability:
  • Professional Statement of Need
  • Medical Opinion Form
  • Proof of receipt of SSI or SSDI
  • Other forms of disability documentation to be determined
Housing Instability

• Meets Minnesota’s definition for homeless
• At-risk of homelessness
• Currently transitioning or have recently transitioned from an institution or licensed or registered setting
• Eligible for waiver services

Housing instability can be documented by:

• Professional Statement of Need
• MnCHOICES Assessment or Long-Term Care Consultation (LTCC) (for persons with a need for Long Term Services and Supports)
• Coordinated Entry Assessment (for persons experiencing homelessness)
Assessed Need for Services

• Requires assistance due to their disability in one of the following areas:
  • Communication
  • Mobility
  • Decision-making
  • Managing challenging behaviors

Assessed need for services can be documented by:

• Professional Statement of Need
• MnCHOICES Assessment or Long-Term Care Consultation (LTCC) (for persons with a need for Long Term Services and Supports)
• Coordinated Entry Assessment (for persons experiencing homelessness)
Everyone receiving Housing Stabilization Services will be required to have a \textit{person-centered service plan}. The person-centered planning process must:

- Be driven by the individual,
- Include the person’s strengths, interests, wants as well as what supports they need, and
- Help the person make an informed choice about their Housing Stabilization Service provider.
Who Does the Person-Centered Plan?

Current roles required to complete plan:

• Waiver case manager—Coordinated Services and Support Plan

• Targeted case manager (Adult Mental Health, Child Mental Health, Vulnerable Adult/Developmental Disability, Child Welfare)—Housing Focused Person Centered plan

• Senior care coordinator—Coordinated Care Plan

New service for people who do not have a Medicaid case manager or senior care coordinator:

• Enrolled Housing Consultation provider—Housing Focused Person-Centered Plan
Accessing Services

**Assessment:**
1. PSN
2. MnChoices/ Long Term Care Consultation (LTCC)
3. Coordinated Entry Assessment

**Plan:**
1. Housing Focused Person Centered Plan (Housing Consultant/Targeted Case Manager)
2. Coordinated Services and Supports Plan (Waiver Case Manager)
3. Coordinated Care Plan (Senior Care Coordinator)

**Housing Stabilization Services Provider Submits:**
1. Assessment
2. Plan
3. Documentation of disability/disabling condition

**Eligibility Review:**
1. Provider notified through MN-ITS that they can begin working with person.
Key to know:

• Assessment and planning for Housing Stabilization Services is primarily the same as the current processes MnCHOICES assessors and waiver case managers use for waiver services.
MnCHOICES
Assessor Role
Assessors play an important role in helping people access Housing Stabilization Services:

- Document the need in the assessment
- Identify the need for housing services
- Capture the need on the Community Support Plan worksheet
- Complete referral for Housing Consultation when there is no case manager with that responsibility
The current MnCHOICES assessment can be used to identify the need for Housing Stabilization Services.

Through the current assessment interview, assessors identify areas of need for which the person requires assistance.

A person who has challenges in the following four areas meet the needs-based criteria for Housing Stabilization Services.

• Communication
• Mobility
• Managing behaviors
• Making decisions
The other area of need is housing instability. While the assessor is completing the housing section, they should identify if the person is:

- homeless
- at risk of homelessness (including could become homeless without continued housing services)
- institutionalized (currently or within last 6 months) or;
- eligible for a waiver (a person with an institutional level of care is also deemed at risk of institutionalization).

Through the assessment if they see a person meets any of these housing instability categories, the person has met this needs-based criteria.
Document the Need in the Housing and Environment Domain

Housing and Environment

Use comment boxes to capture key points and summarize what you have learned or discovered regarding the topic.

1. Discussion notes for exploring alternative living environments:
   - Status of planning or search efforts
   - Note options that have been explored and/or considered
   - Include comments about what is going well (with effort/progress)

   Current rental is being sold and they are required to move. Case’s mother has been trying to locate housing. She reports that they might be discriminated against because after she meets with landlord/their home, she is turned down.

2. Identify persons or agencies assisting individual. If needed, make appropriate referrals.

   They have been trying to relocate on own. Needs assistance to ensure affordable options are found and to manage potential of discrimination.

3. Describe concerns, barriers or issues with effort/progress. Indicate how concerns will be addressed.

   Concerned they will not locate housing in time and will be evicted to street. Worried about discrimination.

4. Concerns with current environment that need to be addressed until move. Including reported or observed safety or sanitation concerns. Make appropriate referrals and/or include in support plan.

   * Informed choice decision: *
   - Yes - relocation goal with assistance is in current plan - retain housing goal in plan
   - Yes - relocation goal with assistance is in current plan and alternative supports are needed to address concerns/barriers - update housing goal in plan
   - Yes - relocation goal with assistance is needed/preferred - create new housing goal in plan
   - No - deciding to not seek alternative housing in coming year; suspend search effort; no longer a goal to move
Summarize what you have learned are the important needs and preferences associated with the person’s current housing or need to move.

Select the most accurate “Informed choice decision” with regard to moving forward with a housing-related goal:

• If person needs to find stable housing, select a response that best aligns with that goal

• If person needs assistance to sustain current living environment, select a response that best aligns with that goal
Identify the Need for Housing Supports

Referrals & Goals (Housing & Environment)

1. "What the person values and wants for their life"
   - Casa feels the support of family is important to her and the quality of her life. To continue living with family,

2. "Support plan implications for meeting the person's identified needs"
   - Casa has needs in decision-making, mobility, and supported communication that affect her ability to independently secure needed alternative housing. She (and her mother) are required to move from current rental due to the sale of the property. Explore housing supports to assist with finding affordable housing that meets their needs.

Referrals Needed:
- Advocacy Services
- Assistive Technology Evaluation
- Disability Rights Line® (1-866-333-2466)
- Environmental Accessibility Consultation
- Follow-Up to Safety Concerns of Lease
- HOME Line: https://homeiswma.org/ (612-728-5767 or 866-866-3546)
- Home Maker Assistance
- Housing Access Services
- Housing Benefits 101 (981001-mn.hc101.org) -- Information about housing
- HUD Law Advisory Services
- Lead Agency Environmental Health Services
- Minnesota Department of Health
- Occupational Therapist
- Pest Control
- Protective Services
- Senior Linkage Line® (1-800-333-2433)
- Other
- Other
- Other
- Other

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Within the **Referrals and Goals** group, the assessor completes the following:

Narrative summary “Support Planning Implications” that prints to both the:

- Assessment Eligibility Summary
- Community Support Plan Summary of Needs

Documents needed referrals in the “Referrals Needed” list that prints to the Community Support Plan “Recommended Referrals” section.
Community Support Plan (CSP) Worksheet

**Supports for me to consider**

☑ Checked items are things we reviewed/discussed  ☐ Checked items are things I indicated I would like to receive or explore

### PERSONAL SUPPORTS/HEALTH
- [ ] Take care of personal needs
- [ ] Get and/or taking medications
- [ ] Maintain home/shopping/chores
- [ ] Have nutritious food
- [ ] Support my physical health
- [ ] Support my emotional well-being

### HOUSING/TRANSPORTATION
- [ ] Find a different place to live
- [ ] Find transportation
- [ ] Plan for vehicle or home modifications support to stay in housing
- [ ] Housing support stay/move (select)

### SELF-DIRECTED OPTIONS
- [ ] Learn about consumer-directed and grant programs
- [ ] Learn about being my own employer for my services
- [ ] Set up my own services
- [ ] Find training or coaching so I can learn to direct my services

### SAFETY SUPPORTS
- [ ] Decision-making
- [ ] Meet my supervision needs
- [ ] Budget/money management
- [ ] Coordinate/monitor services
- [ ] Get equipment/supplies (e.g., vision, emergency response, hearing, communication, etc.)

### HOUSING STABILIZATION SERVICES SUPPORTS
- Behavioral
- Communication
- Decision-making
- Mobility
- Housing Stabilization Services Status
  - Homeless
  - Risk
  - Transition

### MY CAREGIVER OR PARENT
- [ ] Needs help to get information, education and/or coaching
- [ ] Needs help to find support groups
- [ ] Needs respite options

### SKILLS/PARTICIPATION
- [ ] Find employment or get job supports
- [ ] Get school/training supports
- [ ] Find volunteer opportunities
- [ ] Develop home and personal care skills
- [ ] Develop skills that help me participate in my community
- [ ] Do things in my community
- [ ] Apply for ________________

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When the person does not have a waiver/TCM/VA-DD case manager/senior care coordinator, the assessor is responsible to:

- Assist the person in connecting to a housing consultant through the Minnesota Health Care Programs Provider Directory
  - Search for Home and Community Based Services
  - Subtype “Housing Stabilization Services”
- Complete with the person any needed releases of information
- Inform the person of the need to retain his or her copy of the Community Support Plan Worksheet to provide to the housing consultant.
Best practice for people without case managers:
  • Help the person **create a Vault on HB101 and upload the CSP into the Vault**
  • support the person in contacting their chosen housing consultant to help ensure service access
Waiver Case
Manager Role
Role of the Waiver Case Manager

- Begin the process of helping a person move by ensuring that their request for Housing Stabilization Services has been documented in the Coordinated Services and Support Plan (CSSP).
  - If the request occurred at the assessment/reassessment, the need must also be documented in the assessment and Community Support Plan.
- Support the person to choose a transition/sustaining provider to provide Housing Stabilization Services
- Complete the service section to include Housing Stabilization Services in the CSSP (under “other agreements” tab)
- Securely email/mail completed CSSP to chosen provider and request the provider’s signature
  - The **Housing Stabilization Services provider** uploads the information from the CSSP into the DHS eligibility review system.
- Ensure Housing Stabilization Services are coordinated with the rest of the person’s services
- Monitor the person’s progress with the Housing Stabilization Services provider and communicate with other supports as needed
- Complete the **My Move Plan Summary** once the person has identified a place to move
Where in the Community Support Plan can a case manager identify a need for Housing Stabilization Services?

- General plan notes
- What’s Important to the Individual
  - Quality of Life domain
  - Safety and self-preservation domain
  - Housing and Environment domain
- Short and Long-Term Goals
- Action Steps for Goals
- Summary of Needs
- Recommended Referrals
- Anywhere else in the CSP

**The need for Housing Stabilization Services does not have to be documented in all the above spots. Those listed above are the most appropriate spots to identify the need for Housing Stabilization Services.**
Where in the CSSP can a case manager document the need for Housing Stabilization Services?

• General plan notes
• Short and Long-Term Goals
• Action Steps for Goals
• Summary of Programs and Services
• Anywhere else in the CSSP

**The need for Housing Stabilization Services does not have to be documented in all the above spots. Those listed above are the most appropriate spots to identify the need for Housing Stabilization Services.**
Where can Case Managers document the need for Housing Stabilization Services?

General Plan Notes:
Delford is ready to move to a bigger place of his own. He would like to live in a quiet area with neighbors that respect his sobriety. He does not like to use public transportation so it is important for him to live within walking distance of his church and sister. This will also give an opportunity to utilize grocery delivery options. Over the last year, Delford decided to focus in finding employment instead of the expungement process. This is something he needs to work on so that he can move where he wants.

Short and Long-Term Goals

<table>
<thead>
<tr>
<th>Goal Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delford will continue to attend AA at least once every other week and will remain sober.</td>
</tr>
<tr>
<td>Delford will continue to work with his ARMHS worker and therapist to develop and use coping skills to manage his mental health symptoms.</td>
</tr>
<tr>
<td>Delford will continue to volunteer a couple times a month with a local school and increase volunteer opportunities with youth at his church.</td>
</tr>
<tr>
<td>Delford will find a home in a safe neighborhood that is close to his church and sister.</td>
</tr>
<tr>
<td>Delford will work with his IVC provider on the expungement process and to find a home in a safe neighborhood.</td>
</tr>
<tr>
<td>Delford will continue to use his NPS machine to ensure proper dosage and time for his medications.</td>
</tr>
</tbody>
</table>

Action Steps for Goals:

**What will the person do?**
1. Delford will continue to connect with his sponsor and relationships he has formed through AA.
2. Delford will continue to keep a journal and share his highs and lows each week with his therapist and ARMHS worker.
3. Delford will share the church that he hopes to be employed in their youth services program in the future. With the help of his employment services provider, he will build on his experience with youth and complete a resume.
4. With the help of his ILS worker, HSS coordinator and case manager, Delford will create a My Vault account in HB101. He will also learn how to make a good impression on future landlords.
5. Delford will complete and submit his expungement paperwork with the help of his HSS provider.
6. Delford will meet with his nurse monthly to fill his MDE machine.

**What will the case manager do?** Delford’s CADI case manager will continue to connect with him as needed to review progress towards goals. The case manager will refer Delford to his chosen Housing Stabilization Services provider and communicate Delford’s plan and preference with the provider. His case manager will complete the My Move Plan Summary with Delford once Delford identifies his future home in order to help with the transition. Delford’s case manager will connect with providers as needed for regular monitoring of Delford’s progress.
Example of service documentation in the support plan application:
Example of service documentation in the CSSP document:

### Service: Housing Stabilization - Transition - 15 Minutes

<table>
<thead>
<tr>
<th>Start Date</th>
<th>End Date</th>
<th>Procedure Code</th>
<th>Frequency</th>
<th>Units</th>
<th>Rate</th>
<th>Avg Monthly</th>
<th>Total Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>08/01/2020</td>
<td>07/31/2021</td>
<td></td>
<td></td>
<td>600</td>
<td>$17.17</td>
<td>$858.50</td>
<td>$10,302.00</td>
</tr>
</tbody>
</table>

- **NPI/UMPI**: [Redacted]  
- **Status**: Approved  
- **Provider Name**: [Redacted]  
- **Funding Source**: Medicaid State Plan  
- **County of Service**: Ramsey

### Areas of Need
- Supportive Services, Self-Direction, Quality of Life, Personal Security

### Support Instructions
Delford's HSS Coordinator will assist Delford with the expungement process and search for a home within walking distance to his church and sister. The HSS Coordinator will help Delford maintain his account with HB101 and use the tools to help them with his housing search.

### Service Notes
Delford will meet with his HSS Coordinator weekly and as needed.

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### Service: Housing Stabilization - Sustaining - 15 Minutes

<table>
<thead>
<tr>
<th>Start Date</th>
<th>End Date</th>
<th>Procedure Code</th>
<th>Frequency</th>
<th>Units</th>
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</table>

- **NPI/UMPI**: [Redacted]  
- **Status**: Approved  
- **Provider Name**: [Redacted]  
- **Funding Source**: Medicaid State Plan  
- **County of Service**: Ramsey

### Areas of Need
- Personal Security, Supportive Services, Self-Direction, Home Management, Quality of Life

### Support Instructions
Delford’s HSS Coordinator will make sure Delford knows his property manager/landlord once they find Delford’s new home. They will also share the information with the rest of Delford’s team, including adding it to Delford’s HB101 MyVault account. Delford’s HSS Coordinator will also assist Delford in being familiar with what surrounds Delford’s new home and finding different walking paths to Delford’s church and sister.

### Service Notes
Delford and his HSS Coordinator will meet weekly and as needed.
• Use person-first language

• Use the word “person” or the person’s name rather than “client,” “individual,” or “consumer”

• Identify what the person wants or needs to move (ex: finding a place, expungement, actual moving)

• Identify what each support or service is responsible for and any relevant timelines
Reminders to Waiver Case Managers

• Discuss with the person how they want each support/service involved in planning and decision-making

• Reminder to case note conversations with person and team

• Be sure to update the Coordinated Services and Support Plan with:
  • new housing information
  • any significant changes as a result of moving
  • request and document signatures from person, legal representative (if applicable) and other service providers

• Reminder to contact and involve informal supports as the person requests

• New! Housing training for waiver case managers available in TrainLink under “Supporting My Move: A Case Manager’s Role”
• The assessment and plan must be updated annually as with other HCBS services.

• Reassessment is the same process as initial eligibility (MnCHOICES and CSSP update)
Targeted Case Manager Role
Role of Targeted Case Manager in Housing Stabilization Services

- Identifying need for service
- Documenting eligibility for housing stabilization services
- Person-centered planning
- Coordinating housing stabilization services with other services
May complete and sign the Professional Statement of Need, if you meet the professional qualifications. Support them to get one signed if you do not.

Assist the person in obtaining the required documents- MnCHOICES Assessment, Coordinated Entry Assessment and proof of disability.
Housing Stabilization services are state plan Home and Community-based Services (HCBS). They must meet all HCBS federal requirements.

One requirement is that everyone has a person-centered service plan.

Targeted Case Manager’s role is to plan for and support people to access needed services, which is why they are required to do the housing-focused, person-centered plan for Housing Stabilization Services. The plan helps the person they are serving access the needed service.
New Housing Focused Person-Centered Plan Format

COMMUNITY SUPPORTS ADMINISTRATION – HOUSING AND SUPPORT SERVICES

Housing Focused Person-Centered Plan

eDoc #7307
Why do we need to do a different plan?

- HCBS person-centered plans must meet very specific requirements.

- Current plans completed by targeted case managers do not meet the HCBS requirements, the newly developed Housing Focused Person-Centered Plan does.

- The Housing Focused Person-Centered plan focuses primarily on **housing**-related goals, needs, strengths and supports.
<table>
<thead>
<tr>
<th>What do I do with the plan once it’s complete?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Select provider</strong></td>
</tr>
<tr>
<td>Work with the person to identify a Housing Transition or Sustaining provider</td>
</tr>
<tr>
<td><strong>Submit form</strong></td>
</tr>
<tr>
<td>Submit copy of person-centered plan and any documentation to the provider who will upload it into the Housing Stabilization Services Eligibility Review System</td>
</tr>
<tr>
<td><strong>Obtain signature</strong></td>
</tr>
<tr>
<td>Ensure provider returns a signed copy of the plan</td>
</tr>
</tbody>
</table>
Renew annually

Update the plan when:

- A person requests an update
- A person requires a new plan due to significant change
- A person wants to change their Housing Stabilization- transition/sustaining provider
Coordinating Housing Stabilization Services with other services: Role of Targeted Case Manager

- Provide referrals to other services that will support housing
- Help all service providers to work together
- Monitor progress and effectiveness of services
- Ensure there is no duplication of services
If a person has..., who does the assessment and plan?

- Waiver case manager: MnCHOICES and Coordinated Support and Services Plan

- Senior care coordinator: LTCC and Coordinated Care Plan for seniors

- Both waiver case manager/senior care coordinator and a TCM: the waiver case manager/senior care coordinator completes the assessment and plan

- Both waiver case manager and senior care coordinator: the waiver case manager completes the assessment and plan
Housing Stabilization Services Roadshow

Provider Training Updates and Individual Enrollment
• The training for Housing Consultant and Transition/Sustaining providers is available on TrainLink.

• The training is in the “Housing and Support Services” learning center.

• In order to complete the training, every staff member will need a unique key that is generated through TrainLink. It is free and easy to get.

• Staff will need to go through all of the training modules in order to get a certificate of completion. This may take 2-3 sessions to complete.

• Once staff have completed the training, certificates will need to be held by the organization for monitoring purposes by DHS.
Enrolling People in Housing Stabilization Services

• In order to provide Housing Stabilization Services, a person must first be found eligible for the program.

• Eligibility documents are uploaded into the Housing Stabilization Eligibility Request form (DHS-7948).

• Visit DHS eDocs Library to search for this form.

• Once you have entered the form, you will need to submit a reason for your request.
For all new enrollees to these services, Select “Initial Eligibility Request” as your reason for submittal.

You will then be required to submit information for each of the boxes shown.

Make sure you have all of the documentation needed in order to submit this request.
The Recipient Information Section requires:

1. Housing Status
2. Housing Instability
3. Disability Type
4. PMI Number (Person Master Index)
5. Date of Birth
6. Living Situation
7. Address - City, State, ZIP, and County or Tribal Location
If you are the Housing Consultant, you will click yes. If a plan was developed by a waiver or targeted case manager or a care coordinator, you will click no.

- If you click yes, you will need to provide this additional information:
  1. Agency Name
  2. NPI/UMPI
  3. Contact First and Last Name
  4. Zip Code
  5. County or Tribal Location
  6. Phone Number, and Email Address
If you are a Housing Consultant, you need to input the Transition/Sustaining provider’s information as listed in the Housing Focused Person-Centered Plan.

The Housing Transition/Sustaining Provider Information Section requires:

1. Name
2. City, Zip Code, and County or Tribal Location
3. Contact Phone Number
The Attachments Section requires that you submit supporting eligibility documentation. The three areas you will need to attach documents are:

1. Proof of Disability Type
2. Assessment Type
3. Person Centered Plan Type

- Only PDF, Word, Excel, JPG, GIF, PNG, BMP and text files may be uploaded as attachments.
- Make sure you have looked over all of the documents you want to attach to verify they are accurate and up to date.
Here is a list of all documents you could attach to show someone’s proof of disability:

1. Professional Statement of Need
2. State Medical Review Team
3. MA-DX/MA-BX - You do not need to attach anything if you select this option because the DHS eligibility review staff will check this in the review process.
5. Medical Opinion Form
6. Age 65 or over
Here is a list of the assessment types you could attach to show someone’s proof of housing instability and assessed need.

1. Professional Statement of Need - Also meets Proof of Disability

2. Coordinated Entry

3. MnCHOICES Assessment or Long-Term Care Consultation (LTCC).
   - If you are a Housing Consultant, and you select this option, you will submit the Community Support Plan Worksheet (DHS-6791A).
   - If a person has a waiver case manager and you select this option, you won’t need to submit an attachment.
There are two options to choose from for the person centered plan type:

1. **Housing Focused** - This will be selected if you are a Housing Consultant or if someone has a targeted case manager.

2. **Coordinated Services and Supports Plan** - You will select this if someone has a waiver case manager or senior care coordinator.

- Important: If someone has a senior care coordinator, when asked for the attachment, you will submit a Coordinated Care Plan under the “Coordinated Services and Supports Plan” option. The look of this plan may vary based on what type of health plan the person has.
The Submitter Information Section requires:

• Submitter First Name
• Submitter Last Name
DHS Review of Eligibility Request Form

• DHS staff will review documents and then notify the provider if the person’s application has been approved or denied.

• If denied, a notification will be sent to providers and the person with comments as to why the request was denied.

• Approval notifications will be sent via the MN-ITS Mailbox to providers, and to a person through the mail.

• If a person has been approved, providers may begin working with them and start billing for service.
Housing Stabilization Services Eligibility Request System

Other Types of Requests

• ** Renewal Eligibility Request: ** Submit this type of request when a person needs to have their services renewed, which occurs on an annual basis. Providers will submit the same information and attachments as the Initial Eligibility Request.

• ** PCPlan Request: ** Submit this request when a person has their person-centered plan updated. Providers will submit the same information as the Initial Eligibility, except only attach the updated person-centered plan.

• ** Provider Change Request: ** Submit this request when a person selects a new provider. Providers will submit the same information as the Initial Eligibility, except only attach the updated person-centered plan with the new provider listed and signed.
• **Additional Transition/Sustaining Unit Request**: Submit this request when a person will need an additional 150 hours of Transition or Sustaining services.

• Providers will submit the same information as the Initial Eligibility, except only attach the supporting documentation for the exception request.

• Examples include but are not limited to: eviction notices, criminal records, past due bill statements or written complaints from landlords.
Housing Stabilization Services Roadshow

Working with Managed Care Organizations
Currently there are eight MCOs enrolling people in Minnesota:

- Blue Plus
- HealthPartners
- Hennepin Health
- Itasca Medical Care
- Medica
- PrimeWest
- South Country Health Alliance
- UCare
Families and Children:

- Parents and caretakers of a dependent child, pregnant women, low-income adults without a dependent child.

Minnesota Seniors Health Options (MSHO) and Minnesota Senior Care Plus (MSC+):

- Clients age 65 and over, have Medical Assistance, and Medicare Parts A and B.

Special Needs BasicCare:

- Voluntary managed care program that covers health care for people with disabilities who are age 18 through 64, have Medical Assistance, and Medicare Parts A and B.
Provider Enrollment with MCOs for Housing Stabilization Services

Providers steps to complete:

1. Enroll with Minnesota Health Care Programs (MHCP)
2. Contact each MCO to complete any paperwork required to enroll in Housing Stabilization Services with that MCO
3. Bill a person’s MCOs for services
4. Check each month to ensure the person has the same MCO. If not, contact new MCO.
MCO Enrollment for Housing Stabilization Services

• Blue Plus
• HealthPartners
• Hennepin Health, Enrollment Contact: Kue Yang Thao
• IMCare (Itasca Medical Care)
• Medica
• PrimeWest
• South Country
• UCare
MCO Contacts for Housing Stabilization Services

Blue Plus

• Ben Waltz  651-662-2144  benjamin.waltz@bluecrossmn.com

HealthPartners

• Jeffrey Seidenkranz 952-883-6941  Jeffrey.r.seidenkranz@healthpartners.com

IMCare

• Shelley McCauley  Shelley.mccauley@co.itasca.mn.us

Medica

• Becky Bills  952-992-2603  Rebecca.bills@medica.com
MCO Contacts for Housing Stabilization Services

PrimeWest
• Stacey Guggisberg  Stacey.guggisberg@primewest.org

SouthCountry
• Heather Carlson  507-431-6597   HCarlson@mnscha.org

UCare
• Provider Assistance Center  612-676-3300 or 1-888-531-1493

Hennepin Health
• Kue Yang Thao  612-596-0148   Kue.YangThao@hennepin.us
Resources and Contact

• DHS MCO Customer/Member Services Information Webpage
  • MCO Service Phone Numbers

• Provider Portal: Register

• Provider Registration: MHCP Providers Policies and Procedures

DHS Contact:
Mike Flicker
Managed Care Contract Manager
Purchasing and Service Delivery
Email: Michael.j.flicker@state.mn.us
Cell: 320-219-1806
Housing Stabilization Services Roadshow

Impact to the Housing Support Program
2017 legislation for MN to pursue MA housing services:

- Duplication with supplemental services estimated at 50% (not 100%), for people in community-based settings
- Reduction of supplemental service rates by 50% scheduled for July 2021, only for these categories:
  - Long-Term Homeless Supportive Housing
  - Metro Demo
  - Housing with Services Independent Living (not assisted living)
- Reduction not dependent on provider enrollment in MA services
Housing Support Program Impact

- Limited duplication between Supplemental Service Rate and Housing Stabilization Services
Things that won’t change for Housing Support:

- Room and board rates
- Billing in MN-ITS for supplemental services
- Service standards related to Professional Statement of Need
- Documentation
  - Case notes still required
  - Ok to track in the same system as long activities can be reported separately
  - No electronic health record requirement
What should Housing Support providers do?

- Identify which Housing Stabilization Service is a good fit for your agency to provide
- Enroll to become a Housing Stabilization Services provider
- Use the time to develop processes before rates change
- Develop partnerships for assessments, person-centered plans, and billing
- Get technical assistance if needed
Housing Stabilization Services Roadshow

Important Reminders and Additional Resources
Housing Stabilization Services and Other Services

- Housing Stabilization Services duplicates:
  - **Housing Access Coordination** in 1915(c) waivers—these will be removed from waivers, and recipients will access through state plan. People will transition onto Housing Stabilization Services at their annual renewal with their waiver case manager.
  - People will NOT be allowed to receive HSS and the following services at the same time: Relocation Service Coordination, Assertive Community Treatment (ACT), Moving Home Minnesota (MHM)
Housing Stabilization Services and Other Services

- Housing Stabilization Services will NOT duplicate these services. If more intensive housing-related services are needed, clients receiving these services should be referred to Housing Stabilization Services. A person can receive these services and the new benefit:
  - ARMHS
  - Targeted Case Management (TCM) (not housing consultation)
  - 1915(c) waiver services (not Housing consultation)
  - Semi Independent Living Services (SILS)
  - Behavioral Health Homes (BHH)
  - Healthcare care coordination (e.g., through Substance Use Disorder reform services or CCBHC)

- Housing-related grant programs: Adults who are in a grant-funded program and eligible for Housing Stabilization should be referred to the new service, but may continue to also receive grant-funded services if those services fall outside those covered by Housing Stabilization (e.g., support with CD recovery).
Home and Community-Based Services: Conflict of interest requirement

**Assessment**
- Health professional (physician, NP, social worker, etc.) OR
- LTCC certified assessor OR
- Trained CES assessor

**Housing-focused plan**
- Case manager OR
- Enrolled Housing Consultation provider

May be same provider

**Housing Transition and Sustaining Services**
- Enrolled Housing Stabilization Services provider
A conflict of interest exception is required for a provider agency to do the assessment/plan and transition/sustaining service for the same person.

Conflict of interest exceptions are only for provider shortage by:

- geographic area
- cultural/language specific providers

Providers will submit an exception request to DHS to determine if they can waive the conflict of interest.
Important Billing Notes

• All counties enrolled Housing Stabilization Service providers must enroll as a “provider type 18” – not “provider type 45”

• Billing will not occur through SSIS for Housing Stabilization Services

• All fee-for-service billing for Housing Stabilization Services will go through the MN-ITS system

• Tribes will not bill through an encounter rate
Planning Tips and Resources
Think creatively! Some ideas include:

• Combining the new service with Minnesota Supplemental Aid (MSA) Housing Assistance
  • Increased 7/1/2020 to $392 and eligibility expands to people on (or eligible for) SSI relocating to the community from a Housing Support setting (see DHS Bulletin #20-48-04)

• Pairing the new service with Housing Support (f.k.a. group residential housing)
Strategically Plan and Deliver Services

Consider ways to maximize Housing Stabilization Services and integrate it into your community!

• Consider becoming housing consultation service providers for people not receiving MA-funded case management
  • Creates more access to services
  • Frees up community-based providers to offer housing transition/sustaining services

• Consider ways Housing Stabilization Services can help fund parts of the coordinated entry system (i.e., housing transition services)

• Think about how Housing Stabilization Services can cover services paid for through state grant dollars, and how to target those dollars toward services not covered by Medical Assistance
Additional Resources

• DHS Websites
  • Housing Stabilization Services Policy Page
    • Sign up for our mailing list to receive important announcements!
  • MHCP Provider Manual
  • MHCP Provider Directory
    • Search under Home and Community Based Services
    • Subtype “Housing Stabilization Services”
  • Frequently Asked Questions Document (PDF) – updated monthly!

• Webinars
  • General Overview (recorded) on Housing Benefits 101 and Policy Page (PDF only)
  • Targeted case management webinars (recorded, will be posted soon)
    • Mental Health
    • Vulnerable Adult/Developmental Disability
    • Child Welfare (for youth in transition ages 18-21)
Additional Resources

• Housing Benefits 101 (mn hb101.org)
  • Helpful tools for people served, including benefits look-ups, budgeting pathways, and
general information about Housing Stabilization Services (brochure/visual aids)
  • Vault feature, which allows for free, secure document storage and transmission
  • New! Pro Tools, including a Keeping My Housing Plan, to guide the work of housing
sustaining providers

• New! Person-Served Workflow (DHS-7347)

• Reach out to Housing Stabilization Services Team anytime via e-mail at
dhshousingstabilization@state.mn.us
Thank you for your participation!

Visit our [webpage](#) Contact us at: [dhshousingstabilization@state.mn.us](mailto:dhshousingstabilization@state.mn.us)

Sign up for our mailing list to stay updated about our program [here](#).