



Housing Stabilization Services

MSHO/MSO+ and Connect/Connect + Medicare Care Coordinator Role

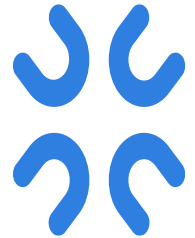
What is housing stabilization services?

- Housing Stabilization Services is a Minnesota Medical Assistance benefit to help people with disabilities, including mental illness and substance use disorder, and seniors find and keep housing.
- People with disabilities often need support to live successfully in the community. However, that support is often unavailable. Affordable housing is not always enough; challenges such as mental illness and developmental disabilities can make it difficult for someone to find housing, budget, interact with landlords and neighbors, and understand the rules of a lease. With the right supports, provided by a professional with knowledge and experience in housing, more people can be successful.
- The purpose of these services is to:
 - Support an individual's transition into housing,
 - Increase long-term stability in housing in the community, and
 - Avoid future periods of homelessness or institutionalization.

Housing stabilization service types

Housing consultation services	Housing transition services	Housing sustaining services
<ul style="list-style-type: none"> Services that assist a person in developing a housing focused person-centered plan, assist the person to access needed state plan services that support housing stability and provide referrals or information about to other needed services. This service is available to people on Medical Assistance who do not have a waiver case manager, mental health targeted case manager or MSHO/MSC+ care coordinator involved to complete an assessment and a person-centered plan of care. 	<ul style="list-style-type: none"> Helps people plan for, find and move to homes of their own in the community by: <ul style="list-style-type: none"> Developing an individualized housing plan Identifying and assisting in resolving barriers to accessing housing Supporting the person in applying for benefits to afford their housing Contacting prospective housing options for availability and information Supporting the person with tenant screening and housing assessment Helping to understand and negotiate a lease Identifying resources to cover moving expenses Ensuring the new living arrangement is safe and ready for move-in 	<p>Supports a person to maintain living in their own home in the community by:</p> <ul style="list-style-type: none"> Prevention and early identification of behaviors that may jeopardize continued housing Assistance with the housing recertification processes Training on being a good tenant, lease compliance, and household management Supporting the person to understand and maintain income and benefits to retain housing Supporting the building of natural housing supports and resources in the community Housing sustaining services do not cover room and board

How services apply to MSHO/MSC+ & Connect/Connect + Medicare



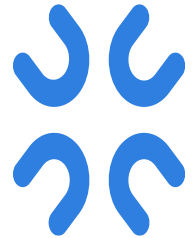
Housing Consultation Services

- Members on MSHO/MSC+ do not qualify for housing consultation services as their care coordinator will fulfil the duties of this role which includes identifying the need for housing stabilization services, ensuring the member meets the criteria for housing stabilization services and completing the Collaborative Care Plan.
- Members on Connect/Connect + Medicare may receive housing consultation services if they do not have a waived case manager or targeted case management.

Housing Transition Services & Housing Sustaining Services

- Members on MSHO/MSC+ who have a need for housing transition services or housing sustaining services will receive assistance from the MSHO/MSC+ care coordinator to help the member select a housing transition services or housing sustaining provider.
- Members on Connect/Connect + Medicare who have a need for housing transition services or housing sustaining services will receive assistance from their case manager or housing consultation service provider to identify a housing transition service provider or housing sustaining service provider.

The role of the MSHO/MSOC+ care coordinator: Eligibility



Need for services due to limitations caused by disability



Housing instability



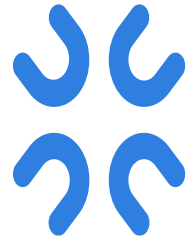
Disability or disability condition

- Members must have support needs in one of the four areas while completing the LTCC:
 - Communication
 - Mobility
 - Managing behaviors
 - Making decisions
- Through the LTCC assessment care coordinators will determine any limitations the member has.
- A member does not need to meet the definition of "dependency" on the LTCC in one of the above categories to qualify

- Members must also have housing instability to qualify for housing stabilization services.
- The member must meet one of the following criteria:
 - Homeless
 - At risk of homelessness (including could become homeless without continued housing services)
 - Institutionalized (currently or within the last 6 months)
 - Eligible for a waiver (a person with an institutional level of care is also deemed at risk of institutionalization)

- Members must meet a defined criteria for disability.
- For the purposes of qualifying for housing stabilization being age 65 or over is a qualifier under the disability and disabling condition category.

The role of the MSHO/MSC+ care coordinator: assessment & planning



- Members must be assessed to determine if they qualify for housing stabilization services.
- The LTCC (DHS- 3428) can be used to assess the need for housing stabilization services.
 - The HRA (DHS- 3428H) **cannot** be used to assess the need for housing stabilization services.
- The care coordinator takes the assessment information and adds housing stabilization services to the Collaborative Care Plan; as they do with other needed and selected services.
- The care plan must indicate which of the four support needs the member meets the criteria for – communication, mobility, managing behaviors or making decisions.
 - E.g. “John needs support **communicating** his needs”.
- The care coordinator helps the member select a housing transition/sustaining provider; as they do with other needed and selected services.
- The care coordinator will follow the same process to receive a plan signature from both the plan’s owner and the HSS provider.
- The completed Collaborative Care Plan is forwarded to the HSS provider.
- The HSS provider uploads information into the DHS eligibility review system.
- The assessment and plan must be updated annually as with other HCBS services.
- Reassessment is the same process as initial eligibility.



Who completes the assessment and plan – MSHO/MSC+

- **MSHO/MSC+ Care Coordinators**
 - Completes the LTCC and Collaborative Care Plan if the member does not have a disability waiver case manager
 - If the member has a disability waiver case manager and MSHO/MSC+ care coordinator the disability waiver case manager completes the assessment and plan.
 - If the member has a Targeted Case Manager and MSHO/MSC+ care coordinator the MSHO/MSC+ care coordinator completes the assessment and plan.

Care Coordinator Role - Connect/Connect + Medicare

The SNBC care coordinator role is not any different for HSS than the care coordinator role in identification and assistance in accessing any other service.

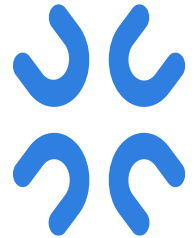
There are no requirements for SNBC CC to conduct the HSS assessment or the person-centered plan.

HSS is an important service as it is understood some disabilities make it difficult for people to search for or secure housing, interact with landlords/neighbors, and understand or follow a lease. The right supports, provided by a professional with knowledge and experience in housing can help resolve barriers some people face in finding and keeping housing.

The HRA does not assess need for Housing Stabilization Services.

The HRA may help identify the members need for HSS and improve the access to services.

Connect/Connect + Medicare Care Coordinator Identifies the Need for HSS



Conversation with member to identify/verify need for housing support.

Summarize and record in case notes what you have learned from the member associated with their current housing or need to move.

Document the need for HSS in the member's care plan.

Record the member decision regarding accessing HSS.

Identify resources available to member to assist with housing needs.

Document support given to the member to obtain HSS.

Identify Resources Available to the Member to Assist with Accessing HSS Connect/Connect + Medicare



Identify if the member is:

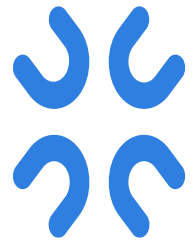
- On a waiver for people with disabilities.
 - Brain Injury (BI), Community Access for Disability Inclusion (CADI), Community Alternative Care (CAC), Developmental Disability (DD)
- Receiving targeted case management
 - Adult Mental Health, Child Mental Health, Vulnerable Adult/Developmental Disability

If the member has MA case management services

- The care coordinator would contact the:
 - Waiver case manager to confer with them regarding the member's needs. It is the responsibility of the waiver case manager to update the coordinated services and supports plan (CSSP) with Housing Stabilization Services to support the member's access to HSS.
 - Targeted case manager (TCM), provided the member is not on a waiver, then the TCM completes the assessment and the Housing Focused Person-Centered plan (HFPCP) to support the member's access to HSS.

If the member is not opened to case management services complete a care coordinator can refer the member to a housing consultation provider, who can determine if the member meets eligibility criteria for HSS

Duplicative Services

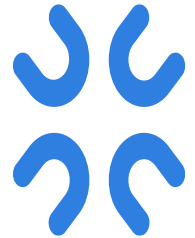


If the member is receiving the following services HSS is not available to them as these services are duplicative of HSS:

- Assertive Community Treatment (ACT)
- Living in an institution receiving Relocation Service Coordination (RSC)
- Moving Home Minnesota (MHM)

If the care coordinator know who the RSC, ACT or MHM provider is they should contact the provider to share the member's identified housing needs or concerns.

Frequently Asked Questions



Housing stabilization services & relocation services are duplicative. When should I use relocation services versus housing stabilization services.

- If a member is in an institution the ideal service would be relocation services, as the provider can bill for services while the member is institutionalized.
- If a member has used up their 180 days of relocation services they can move onto housing stabilization services

Where can I find a list of housing stabilization services providers?

- You can find a list of providers on the MHCP Provider Directory [here](#) under Type: Home and Community Based Services and Sub-Type: Housing Stabilization Services.

I work for a delegate agency that also provides housing transition or housing sustaining services. Can a member receive these services from the agency I work for?

- This is not allowable under the CMS conflict of interest guidelines.

How are these services billed? Is there anything the care coordinator needs to authorize?

- These services are billed under the member's MA benefit through UCare. Care coordinators do not authorize this service. This service is not included in EW budgets.



Questions?
Email

clinicailliaison@ucare.org