UCare Connect/Connect + Medicare and MSC+/MSHO

Care Coordination and Long-Term Services and Supports

Title: Housing Stabilization Services (HSS)

Purpose: To explain housing stabilization services and the role of a care coordinator

Summary: Housing Stabilization Services is a Minnesota Medical Assistance benefit to help people with disabilities, including mental illness, substance use disorder, and seniors, find and keep housing. HSS providers can be found on MinnesotaHelp.info.

The purpose of HSS 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.

Definitions:

Housing consultation

- 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 (TCM) or MSC+/MSHO care coordinator involved to complete an assessment and a person-centered plan of care.

Housing transition services

- Helps people plan for, find, and move to homes of their own in the community by:
    - 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

Housing transition: moving expenses

- Members receiving HSS-transition services and transitioning out of an eligible living situation into their own home may also be eligible for moving expenses. The transition must be to a less-restrictive living arrangement.
- Eligible living situations:
    - Medicaid-funded institutional setting
    - Currently homeless, and/or self-reports having stayed in a shelter in the last 12 months *OR*
    - Leaving specific provider care environments
- Moving expenses are a $3,000 benefit component that a member can access when moving into their own home within an approved HSS eligibility span.
    - The list of allowable items can be found on the DHS page for housing stabilization services

Housing sustaining

- Supports a person to maintain living in their own home in the community by:
  - Prevention and early identification of behaviors that may jeopardize continued housing
  - Assistance with the housing recertification process
  - 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

How Services Apply to MSC+/MSHO Members

Housing Consultation Services

Members do not qualify for housing consultation services as their care coordinator will fulfill 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 Support Plan.

Housing Transition Services & Housing Sustaining Services

Members who have a need for housing transition services or housing sustaining services will receive assistance from the MSC+/MSHO care coordinator to help the member select a housing transition services or housing sustaining provider.

MSC+/MSHO Care Coordinator Roles and Responsibilities

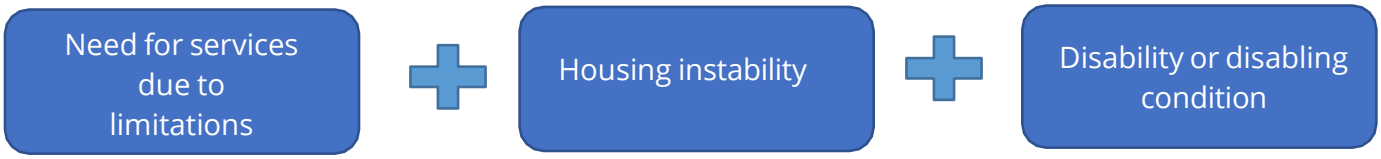
Assessment

Members must be assessed to determine if they qualify for housing stabilization services.

- If the member has a Targeted Case Manager (TCM) and MSC+/MSHO care coordinator, the MSC+/MSHO care coordinator completes the assessment and support plan.
- If the member has a disability waiver case manager and MSC+/MSHO care coordinator, the disability waiver case manager completes the MnCHOICES assessment and Support Plan.

The MnCHOICES Assessment, if completed within 12 months at the time of the housing stabilization services eligibility review, can be used to assess the need for housing stabilization services. The MnCHOICES HRA-MCO **cannot** be used to assess the need for housing stabilization services.

Eligibility



Need for services due to limitations

Members must have identified support needs in one of the four areas while completing the MnCHOICES Assessment:

- Communication
- Mobility
- Managing behaviors
- Making decisions

Through the MnCHOICES Assessment, care coordinators will determine any limitations the member has. When a care coordinator identifies a limitation in one of these areas, the member has met the needs-based criteria. A member does not need to meet the definition of "dependency" on the MnCHOICES in one of the above categories to qualify.

Housing instability

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)

Disability or disabling condition

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.

Planning

1. The care coordinator utilizes the MnCHOICES assessment information and adds housing stabilization services to the MnCHOICES Support Plan.
   - The Support 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".
2. The care coordinator provides a list of providers to the member to assist in the member's choice of provider.
3. The care coordinator will work with the member and HSS provider to receive a signature from both for the Support Plan.
4. The completed Support Plan is shared with the HSS provider.
   - The HSS provider uploads information into the DHS eligibility review system.
5. The assessment and Support Plan must be updated annually as with other HCBS services.
6. Reassessment is the same process as initial eligibility.

How Services Apply to Connect/Connect + Medicare Members

Housing Consultation Services

Members may receive housing consultation services from an HSS provider if they do not have a county waiver case manager or TCM. If the member is open to CADI/CAD/BI/DD waiver or receives TCM, the case manager fulfills the duties of this role. HSS providers can be found on MinnesotaHelp.info.

Housing Transition Services & Housing Sustaining Services

Members who have a need for housing transition services or housing sustaining services will receive assistance from the person who completed their assessment and coordinated the support plan.

Connect/Connect + Medicare Care Coordinator Role & Responsibility

Assessment

SNBC care coordinators do not complete the MnCHOICES Assessment and Support Plan needed to access HSS.

When a member who has a Targeted Case Manager (TCM) or waiver case manager, the care coordinator should notify the TCM or waiver case manager that the member has a need for housing stabilization services, and the case manager is responsible for completing the assessment.

- If a member has both TCM and a waiver case manager, the waiver case manager completes the assessment.

For members who do not have a TCM or waiver case manager, the care coordinator may make referrals to housing consultation service providers.

- If the member has additional needs, consider a referral to the member's county of residence for a MnCHOICES assessment.
- Members must have consented to referrals.

Frequently Asked Questions

Housing stabilization services & relocation service coordination 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 utilized their 180 days of relocation services, the member can move onto housing stabilization services.

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

- Providers can be found on MinnesotaHelp.info.

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 and are not included in EW budgets.

Do I need to complete the Housing Stabilization Eligibility Request (DHS-7948) or Housing Focused Person-Centered Plan (DHS-7037)?

- No, these forms should not be completed by care coordinators.