August 6th, 2020

HealthPartners/Bluestone Training

Agenda

- 1. Clinic Closures
- 2. Transitional HRA
- 3. PCA Process Updates
- 4. Housing Stabilization Services
- 5. RS Tool Launch Check-In
- 6. MA Renewals

Clinic Closures

- Received impact list from claims
- Having our Data Analysts add information to report (CC name, utilization, county, high cost, language, race/ethnicity) for easier prioritization
- Impacted MSHO/MSC+ members will be communicated to you

Transitional HRA

- Shared with Jodi this week
- Start using for new August enrollees/program changes
- Complete comprehensive assessment and care plan if there have been significant changes OR you did not receive all of the required documentation

PCA Process Updates

BS CC to:

- Mail PCA assess to member

(If completing a remote assessment, include an extra copy of the signature page)

- Fax MD Comm form to PCP
- Email PCA assessment to medicalpolicy@healthpartners.com

Auth dates will be for 1 year and align with next HRA date

Housing Stabilization Services (HSS)

A New DHS Medicaid Benefit

When

- Went live 7/20/2020

What is "HSS"?

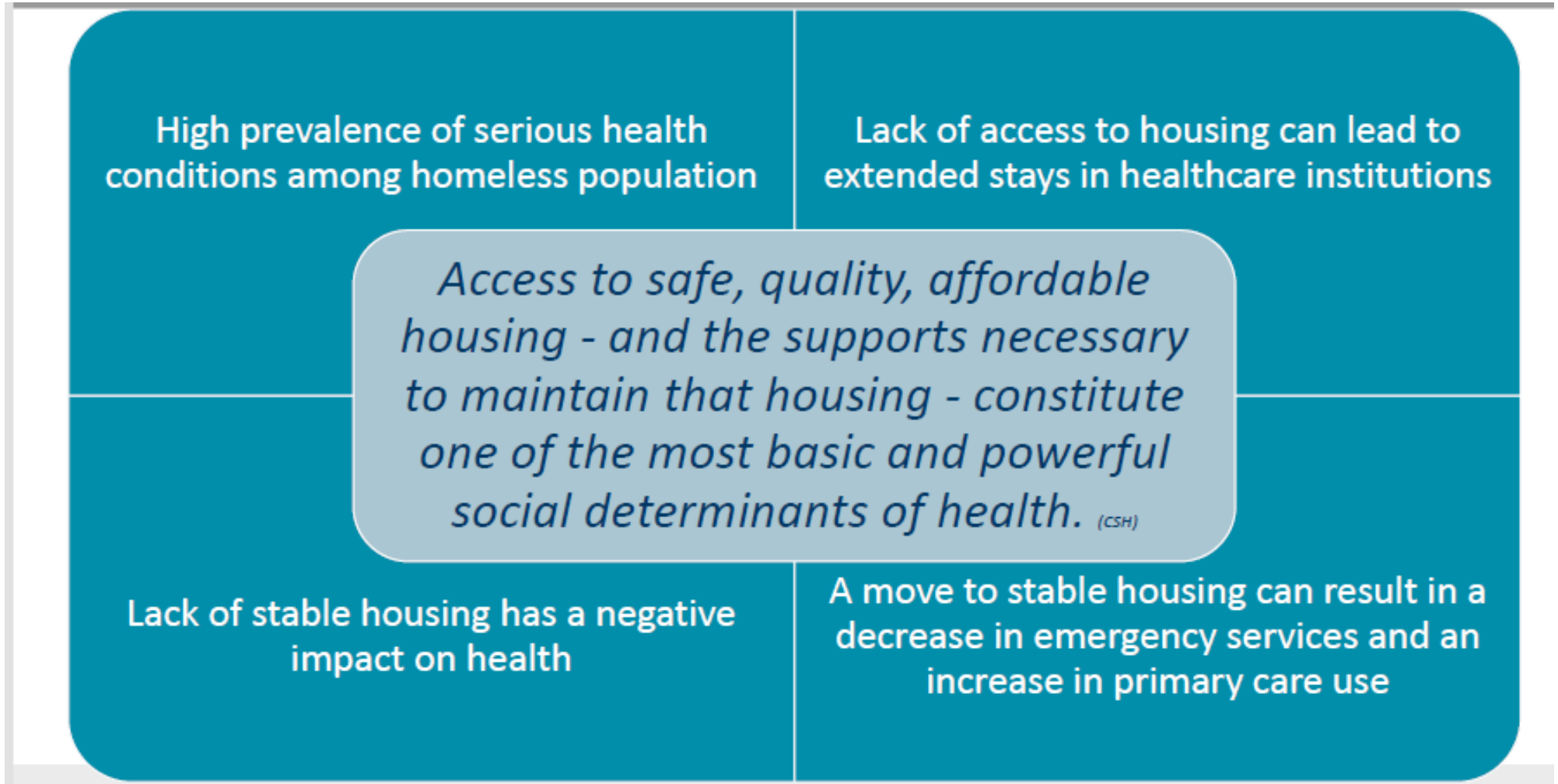
- Supportive service addressing housing needs for Medicaid program populations (**NOT** MinnesotaCare/MnSure) who qualify
  - MSHO/MSC+
  - SNBC
  - PMAP
- Main service components include:
  - Transition Services
  - Sustaining Services
- This is a state plan Medicaid benefit- **NOT** a waiver benefit
  - Does not count towards case mix cap

Purpose of HSS

- Support an individual's transition into housing
- Increase long-term stability in housing in the community
- Avoid future periods of homelessness or institutionalization.

★ First service in the nation that links housing stability/homelessness to someone's overall health and wellbeing

"Access to safe, quality, affordable housing-and the supports necessary to maintain that housing- constitute one of the most basic and powerful social determinants of health"- Corporation for Supportive Housing (CSH)



Making the connection: Housing and Health

2 Core Services

TRANSITION SERVICES **Community supports that help people plan for, find, and move into housing.**	SUSTAINING SERVICES **Community supports that help a person maintain housing.**
• Creating a **housing transition plan**, including helping a person understand and develop a budget. • Assisting with the **housing search** and application process. • Identifying and assisting in **resolving barriers** to accessing housing, including identifying resources to cover moving expenses, deposits, application fees, etc. • **Securing additional services**, benefits and resources to support housing. • Helping a person **organize their move** and ensuring the new living arrangement is safe and ready for move-in.	• Creating a **housing stabilization plan.** • **Education** on roles, rights, and responsibilities of the tenant and property manager, including training on being a good tenant, lease compliance, and household management. • Coaching to develop and **maintain key relationships** with property managers and neighbors. • Advocacy with community resources to **prevent eviction** when housing is at risk. • Prevention and **early identification of behaviors** that may jeopardize continued housing. • **Assistance with maintaining services** and supports, including applying for benefits to retain housing. • Supporting the **building of natural housing supports** and resources in the community.

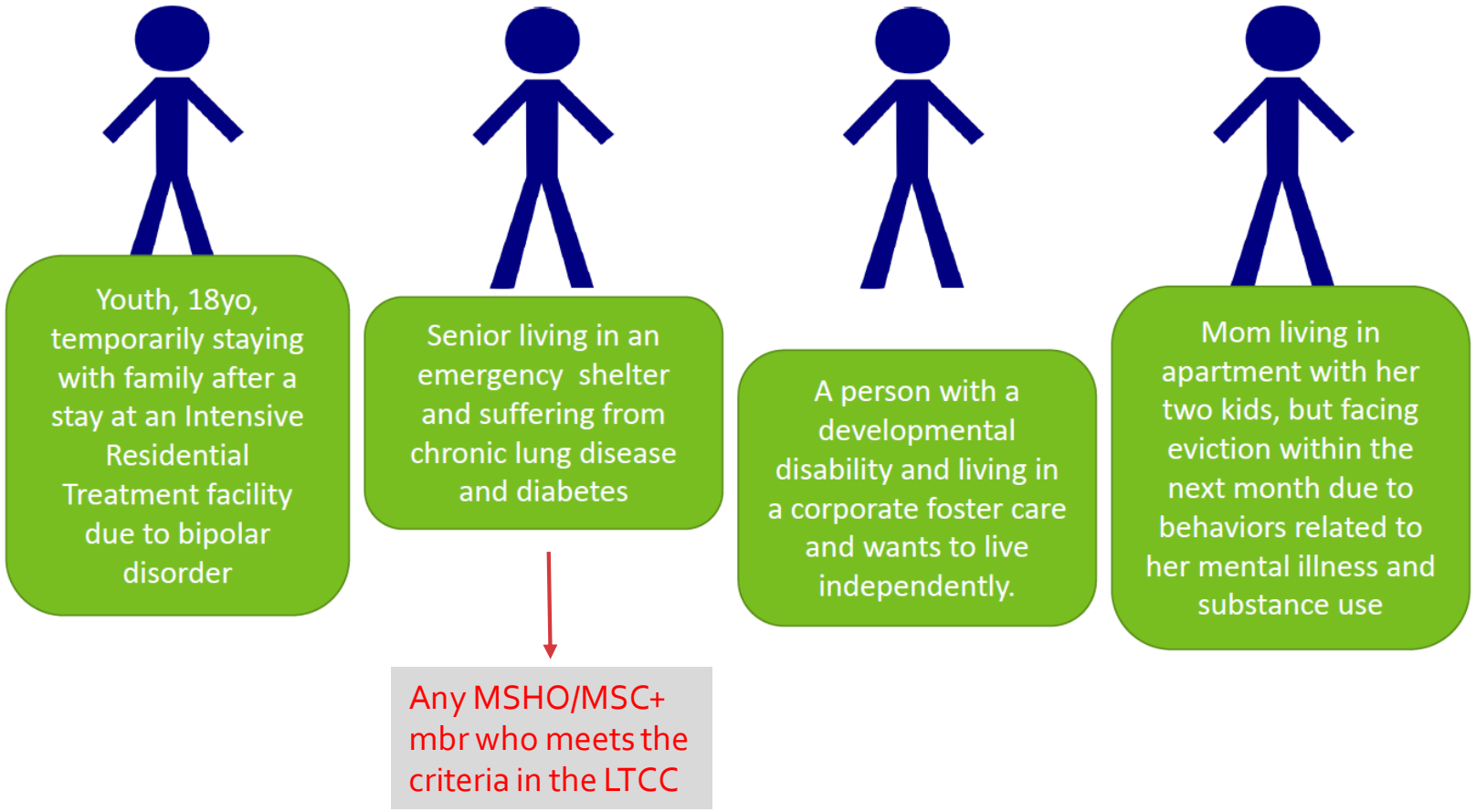
Member Qualifications

- All Medicaid products EXCEPT MinnesotaCare

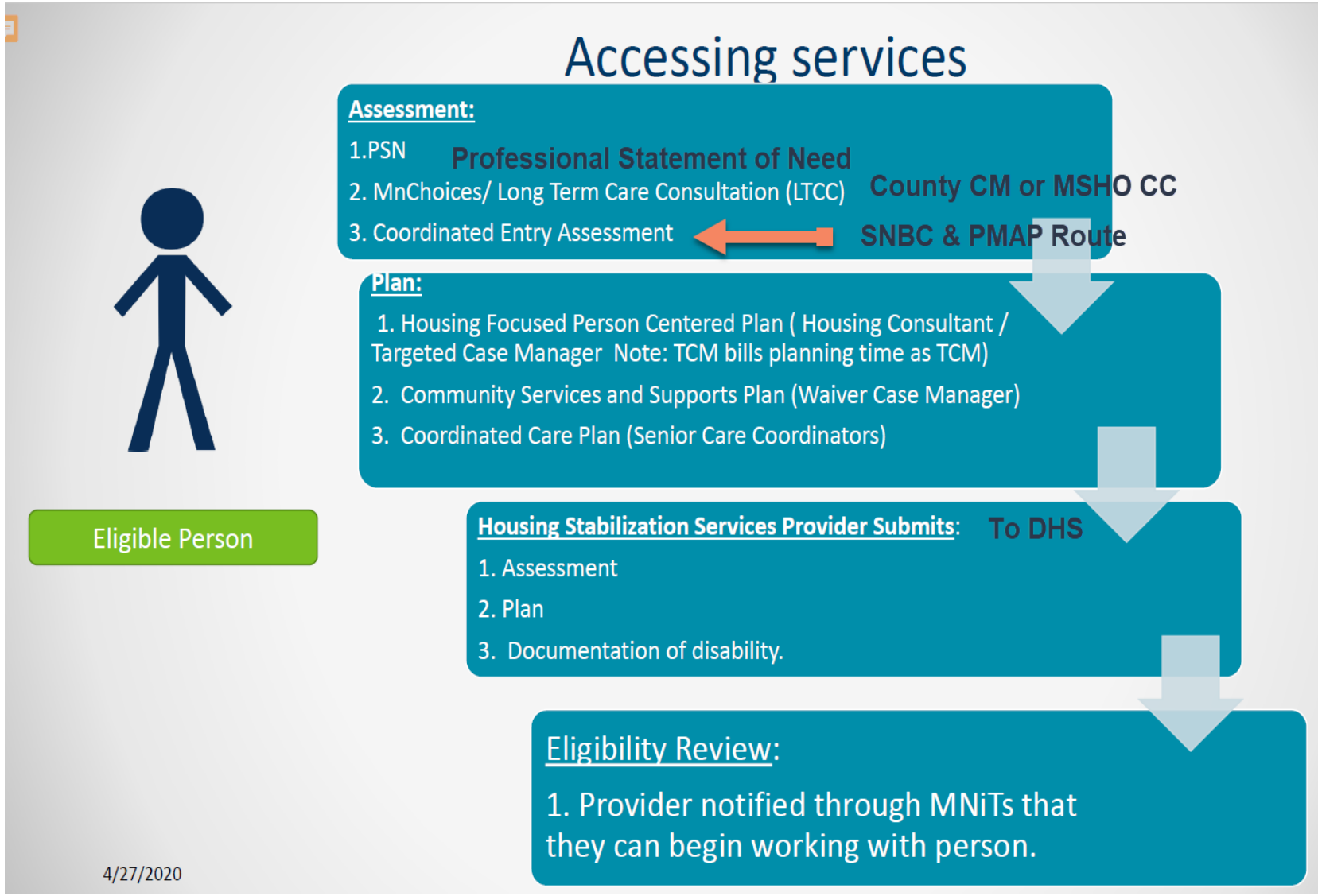
MSHO/MSC+ Members automatically qualify if they meet the criteria in the LTCC

Person's Targeted

Target population: Who will benefit from these services?



Accessing Housing Stabilization Services



Step 1 Assessment

Professional Statement of Need	LTCC /MnCHOICES Assessment	Coordinated Entry assessment
Completed by a clinician who can certify proof of disability.	MSHO/MSC+, other waivered programs *non-waivered members are eligible for HSS, but need to be assessed using the LTCC	SNBC & PMAP (for persons experiencing homelessness)

LTCC Assessed Need

Requires assistance due to their dependency **OR LIMITATION** in one of the following areas:

- Communication
- Mobility
- Decision-making
- Managing challenging behaviors

Housing Risk

- Homelessness
- At risk for homelessness (including could become homeless without continued housing services)
- Institutionalized- currently or the last 6 months
- Eligible for waiver

RI

Ba.16 My current housing type:

LTC SD 32 [ ]

01	Homeless	04	Board & Lodge	11	NF/Certified Boarding Care
02	ICF/DD	05	Foster Care	12	Noncertified Boarding Care
03	Hospital	09	Own Home, Apartment	16	Correctional facility

Ba.18 Who do you currently live with?

LTC SD 27 [ ]

01	Living alone	04	Living in congregate setting
02	Living with spouse/parents	05	Homeless
03	Living with family/friend/ significant other	06	Would live alone/be homeless without current housing type

Minnesota's Definition of Homelessness

An individual or family is considered homeless when they lack a fixed, adequate nighttime residence (note that 'couch surfers' are homeless)

At-risk of homelessness occurs when (a) the individual or family is faced with a situation or set of circumstances likely to cause the household to become homeless, including but not limited to: doubled-up living arrangements where the individual's name is not on a lease, living in a condemned building without a place to move, having arrears in rent/utility payments, receiving an eviction notice without a place to move and/or living in a temporary or transitional housing that carries time limits; or (b) the person, previously homeless, will be discharged from a correctional, medical, mental health or substance use disorder treatment center, and lacks sufficient resources to pay for housing, and does not have a permanent place to live.

Step 2
The Care Plan

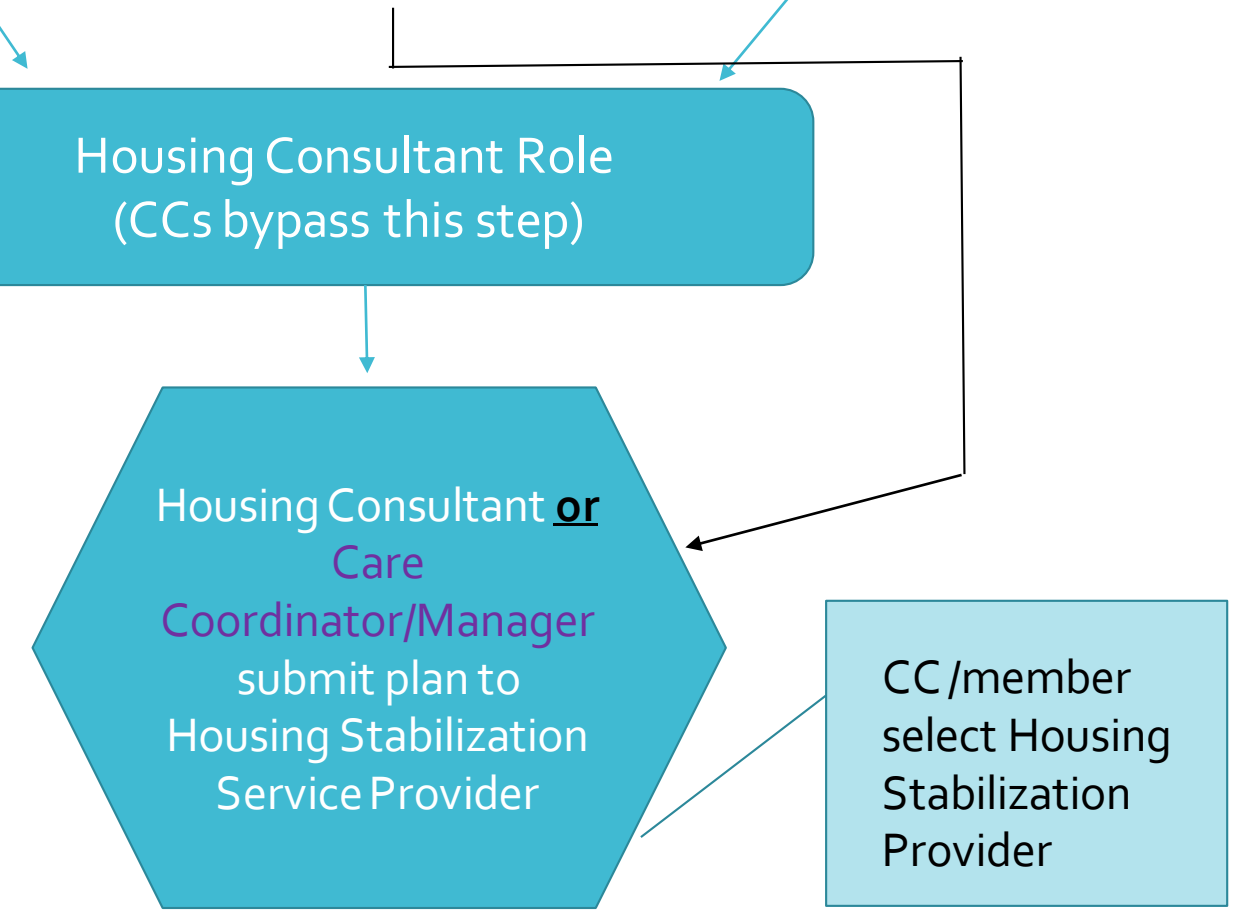
Everyone receiving HSS will be required to have a person centered service plan. The person-centered planning process must:

- 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 provider

Your care plans meet these requirements

Who Creates the Care Plan?

Professional Statement of Need	LTCC Assessment	Coordinated Entry
Housing Consultant Creates the Plan	Care Coordinator or County Waivered Case Manager Creates the Plan	Housing Consultant creates the plan

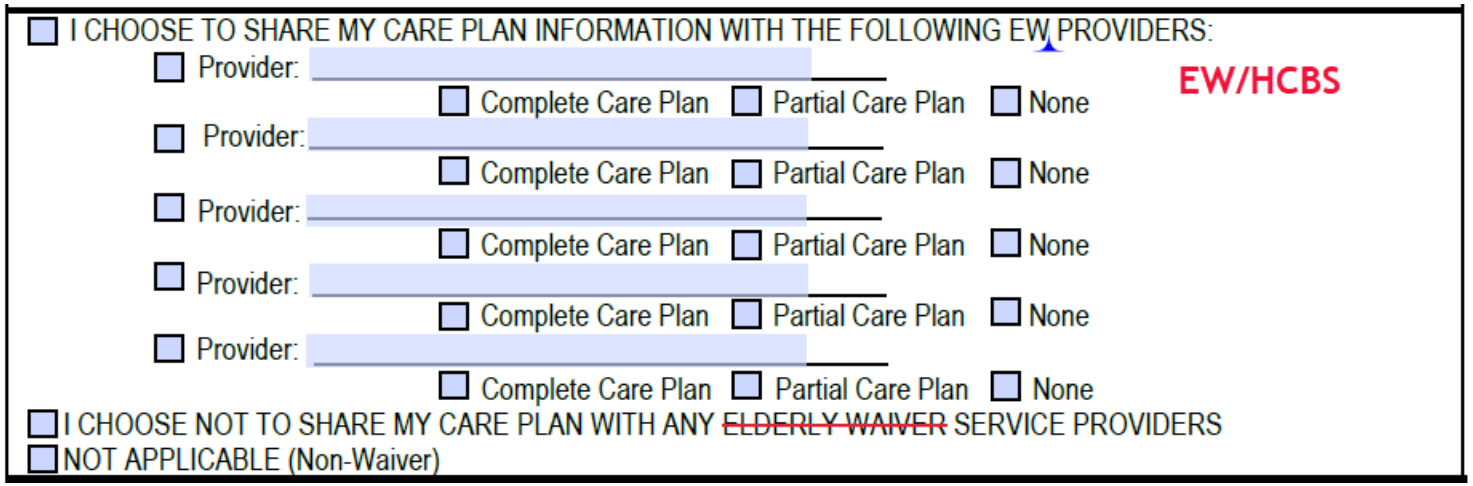


Care Plans & CarePartner

- MSHO Goal needs to indicate of Housing Stabilization Services.
  - Housing Stabilization Services - Transition
  - Housing Stabilization Services – Sustaining
- Create a goal for HSS depending on type of service:
  - **Transition Goal** (moving from a less restrictive setting): Move to a less restrictive setting;
  - **Transition Goal** (no current housing): Obtain permanent housing
  - **Sustaining Goal**: Will maintain current housing
- CC Intervention: CC Referral to housing provider
- Member Action: Accept services and work with housing provider

Provider Signature

- It's needed. Modifying the signature sheets.
- Collaborative Care Plan will be updated



Side Step Housing Consultation Provider

- Required to use one if not in MSHO/MSC+ or other waiver
- Creates Housing Focused Person Centered Plan
- Submits plan, and documentation of disability to DHS
- Refers to a Housing Stabilization Provider
- Monitors and updates the plan annually or more frequently if the person requests a plan change, experiences a change in circumstance or wants to change housing stabilization provider

Side Step Provider Enrollment

DHS Enrolled HSS Providers

Side Step Rates/Codes

Service Description	Rate	Procedure Code	Unit
Housing Consultation	$174.22	T2024	Per session
Housing Transition	$17.17	H2015 U8	Per 15-minute unit
Housing Sustaining	$17.17	H2015 U8/TS	Per 15-minute unit

End of Referral Process

- You are done with the referral process at this point

Step 3: Submission of Plan to DHS

- Housing Stabilization Service Provider submits your care plan to DHS for approval
- Per DHS, MSHO/MSC+ care plans will be automatically approved

Step 4: DHS Notification to Providers

- Housing Stabilization Services provider is notified through MnITS that they can begin services

Behind the Scenes: Ongoing DHS Notification Process

- DHS will send a notification via MN-ITs to health plans when any of these events occur:
  - A person is eligible for HSS- a PSN or Coordinated Entry assessment is received OR county/previous health plan initiated HSS process
  - A person changes HSS providers.
  - The person-centered plan is updated
  - DHS grants an additional 150 hours of HSS Transition or Sustaining service
- Notifications are PDF letters that also go to providers.
  - Include the Client Name, DOB, PMI Number, HSS Eligibility Start and End Date, Person-Centered Plan start and end date, Name and NPI of the Housing Consultation Provider, Name and NPI of the Housing Stabilization Services Provider.
- We will receive a monthly report from Government Programs with the above information

Impacts to Other Services

- Transitional Care/Relocation: Can not be used along with Relocation/Transition Services. Duplication
- ILS: Not a duplication for 1x/year MA recertification paperwork
  - 257 ILS S&Is for monthly assistance
  - Bill pay, housing search, paperwork
- Moving Home Minnesota- duplication
- My Move Plan- continue to use/complete this form

Other

- Interpreter services – covered
- Transportation – covered and provided to and from meetings for HSS. Available through Ride Care

RS Tool Launch

- Check-in

MA Renewals: DHS Health Emergency Extension

DEPARTMENT OF HUMAN SERVICES

Housing Stabilization Services

The Minnesota Department of Human Services (DHS) received notification from the Centers for Medicare and Medicaid Services (CMS) that the federal public health emergency was extended on July 24, 2020, for an additional 90 days.

What this means for Housing Stabilization Services:

- Conflict of interest requirements remain waived
- Signature of person and provider on the person-centered plan remain waived
- State oversight of the home and community-based settings requirements remains waived, although providers are still expected to comply with the standard.
- No limit on remote support and are working on revised limits during COVID
- Although conflict of interest requirements are waived, and providers aren't applying to the state for conflict of interest waivers, best practice is to have a separation of assessment/planning and service delivery within the same organization.See information about the guidelines in the policy manual under Conflict of Interest Requirements and Exception.

CMS will notify DHS when the COVID-19 public health emergency has ended. Upon conclusion of the public health emergency, DHS will notify Housing Stabilization Services providers that the home and community-based services requirements are reinstated and provide a timeline for compliance.

Questions?