Community Feedback on Housing Stabilization Services

Background

Minnesota's Medical Assistance Housing Stabilization Services benefit was implemented in July 2020. It was uniquely approved as the first in the nation to be part of a State Plan Home and Community-Based (HCBS) service plan option. The services include three distinct components:

- **Housing Consultation**: to develop a person-centered housing plan for individuals without Medicaid-funded case management
- **Housing Transition Services**: to assist a person to find housing (can include some moving expenses for people moving out of Medicaid-funded institution or leaving a provider-controlled setting into their own community-based housing setting)
- **Housing Sustaining Services**: to assist a person to maintain housing in their own community-based housing setting

Hearth Connection Role in Community Feedback

Hearth Connection actively gathered stakeholder feedback about Housing Stabilization Services (HSS) in various forums.

Streamlining Conversations

Beginning in January 2022, Hearth Connection streamlined stakeholder conversations regarding HSS across the Metro Region to reduce the number of duplicative meetings held and attended by multiple stakeholders. This convening was initially at the request of housing leadership among the seven Metro Region counties in the Regional Metro Committee (RMC), a committee operating under a Joint Powers Agreement to collectively make decisions related to housing initiatives and funding.

Blue Cross and Blue Shield of Minnesota (BCBS) funded a Hearth Connection-contracted consultant (which became a staff position six months later) to bring together housing and service providers, Minnesota Department of Human Services (DHS) policy staff, community technical assistance consultants also known as the "HSS TA Team", county staff, managed care organization staff, Continuum of Care staff, advocates and philanthropy. The intent of centralizing these conversations was also to reduce rumors and conflicting information circulating in the community at that time and to provide a forum for everyone to hear the same information. When several providers expressed hesitancy to share questions and concerns directly with DHS because they reported they had not received responses or received conflicting information from different parties over time, DHS agreed that Hearth Connection would provide a de-identified "drop box" for community providers to share questions and concerns. In addition, Hearth Connection surveyed stakeholders three times over 16 months to identify challenges and opportunities. Hearth

Connection worked closely with DHS to share these questions and feedback and made time for problem solving and clarification from DHS in the monthly forum (See Attachment A).

Meetings were held monthly through September 2022, which then moved to quarterly and expanded to statewide at the request of Greater Minnesota providers and county staff. Participation ranged from 38 to over 100 individuals, with an average of 50 participants at each convening.

The final statewide meeting was held in April 2023 when at the time of staffing changes, the DHS team stated they intended to host monthly HSS meetings with stakeholders. There was mutual agreement that this would be duplicative, and Hearth Connection discontinued its convening of this forum. DHS did not continue stakeholder meetings, and communities around the state have established and maintained their own formal and informal HSS conversation forums.

Community Convening on Long-term Solutions to Homelessness

Following high level recommendations in a Hearth Connection-commissioned report by Wilder Research on "Accessing and Maintaining Long-Term Solutions to Homelessness" released in March 2023, Hearth Connection launched community engagement sessions with more than 500 stakeholders across Minnesota (see attachment B) to identify actionable long-term solutions to homelessness and to inform administrative and legislative advocacy agendas.

During the 75 community engagement sessions, Hearth Connection heard from people representing 207 organizations, including service and housing providers, behavioral health providers, people experiencing homelessness currently or previously, local and state government representatives, Continuum of Care members and staff, advocates, philanthropy, managed care organization staff, and interested community members. Eleven of the conversations were solely for people experiencing housing instability or homelessness. In nearly all 75 of these conversations, service funding and processes, including Medicaid and HSS, were highlighted as critical components that are currently insufficient to meet the needs and can be difficult to access or administer.

Intermediary

Hearth Connection serves as an intermediary of government funding for 34 organizations across Minnesota, including two tribes, to administer and provide permanent supportive housing for people with long histories of homelessness. Through these contracted relationships, Hearth Connection maintains regular contact with providers around the state who have considered, refrained, and/or experienced administration of HSS in their work to end homelessness. These organizations provide frequent and ongoing feedback on challenges and opportunities related to HSS (see attachment C).

Managed Care Organizations

Since 2022, Hearth Connection engaged six of the nine Managed Care Organizations (MCOs) in Minnesota to discuss ways to support service delivery and long-term solutions to homelessness. Each MCO faces unique challenges to establish infrastructure, maintain staffing, and keep up to date on federal and state requirements to administer HSS. While deeply committed to effective processes and communication, many experienced staffing turnovers, much like the service provider communities statewide.

At the request and with support from BCBS, Hearth Connection conducted a set of statewide provider conversations to identify strategies to make HSS more accessible to people experiencing housing instability and the organizations serving them. Intentionally composed of organizations serving people experiencing housing instability, these groups included those actively billing HSS, those who stopped billing due to insufficient revenue for staff retention, and those interested in leveraging HSS but lacking the administrative infrastructure. In addition, stakeholders included organizations serving older adults, non-English speaking communities, and culturally specific providers serving East Asian, Somali, and Indigenous communities. The feedback heard in these meetings was consistent with that heard in other forums, plus some additional specificity about unique barriers for Greater Minnesota residents to access HSS.

Community Feedback on Housing Stabilization Services

The challenges and opportunities regarding HSS shared in Hearth Connection forums held similar themes across several years, statewide geographic representation, as well as providers targeting populations with varying demographics and culture. Feedback pertains to the design of the benefit, provider and individual eligibility, billing and payment structure, and quality assurance.

HSS Topic Area	Identified Barrier/Impact	Suggested Solutions
Benefit Design	Eligible activities are limited	Expand MN Statute and CMS approval to include outreach, transportation, group services, email communications, more indirect service-related communication, culturally specific service activities Explore enhanced federal funding for MN to offer more culturally specific resources for non-English speaking participants Consider different Medicaid authority and amend MN Statute to expand services or increase flexibility
	Conflict of interest policy restricts client engagement and increases complexity for individuals and providers	Consider homelessness as population eligible for cultural exception under current 1915(i) authority Consider different Medicaid authority to remove conflict of interest policy
Provider Eligibility		Expand DHS capacity to train and support providers through the enrollment process

	Provider eligibility is complex, time consuming, and expensive	Consider different Medicaid authority and amend MN Statute to remove or reduce fees
Individual Eligibility	Qualified professionals are reluctant or unwilling to verify disability or disabling condition due to confusion about the form	Simplify forms used to verify eligibility Provide more communication and training to qualified professionals to understand process and intent
	Individual eligibility determinations are not processed timely	Expand DHS capacity to support eligibility processing Reduce eligibility processing to a percentage of applications instead of all Consider methods for presumptive eligibility using known information from state and MCO data Consider different Medicaid authority and amend MN Statute to pay for technology solutions and simplify eligibility processes
	Pre-existing individual eligibility is not visible for recipients or providers, resulting in lack of transparency and flexibility around choosing and changing providers	Expand DHS capacity to support requests to confirm HSS eligibility and provider assignment including clarity on how to transfer providers according to individual choice Consider centralized database with portal for authorized users
Billing and Payment Structure	Rates are not enough to cover costs	Increase rates
	15-minute increment billing is problematic	Change billing increment to daily or monthly
	MCO billing and payment system is more complex than MHCP Fee-for-Service model	Consider statewide third-party administrator Consider different Medicaid authority and amend MN Statute to pay for technology solutions and simplify billing and payment processes
	State Housing Support program rate reduction result	Amend MN Statute to restore standard Housing Support

	in lost revenue, compliance issues, and reduced services	Supplemental Service rate and train on duplication compliance
	Tribal health services do not receive 100% federal reimbursement with HSS rates as they would with the Tribal Encounter Rate to address disparities of American Indians experiencing homelessness and living in healthcare institutions	Amend State Plan Amendment and MN Statute to add Housing Services to allowable Tribal Encounter Rate reimbursement
Quality Assurance	Many providers are not familiar with community-based housing and service models, referring people to higher levels of care than needed	Expand DHS capacity to train providers
	Policies on integration with other funding is not clear, consistent or accessible	Expand DHS capacity to work with policy staff across multiple programs and community members to clarify and publish on website Consider full scope of need and amount needed when defining duplication, not just activity
	Reports of predatory activity to enroll individuals without their knowledge are increasing, causing confusion and disruption in other services	Expand DHS capacity to address predatory activities
	Lack of centralized reporting and response mechanism to report program integrity issues	Expand DHS capacity to centralize and communicate reporting and response processes and policies

Benefit Design

Eligible activities

There is widespread recognition among stakeholders that HSS has the potential to provide a robust set of services, especially considering the combination of Housing Transition Services and Housing Sustaining Services. However, several gaps are identified by stakeholders in both the Metro Region and Greater Minnesota rural and Tribal Communities to make the service successful, including:

- Expand outreach to locate and maintain contact with individual
- Expand transportation to necessary appointments and meetings (without client in the vehicle)
- Group Services (e.g., tenant/landlord rights training, budgeting class to be lease compliant)
- Allow email communication with individuals in addition to phone and text

> *"I just put 1000 miles on my car in 2 weeks to meet people [for HSS services]. That was for 15 client encounters, and each lasted less than an hour and only some where I traveled with the client. This is what we're up against financially."*
>
> HSS provider in Greater Minnesota

- Expand allowable percentage of indirect service-related communications and planning with landlords, property managers, and other members of an individual's care team
- Expand reimbursement for culturally specific models of support services (e.g., allow payment for two provider staff to meet in person with non-English speaking participants – one to focus on service provision and another to provide language services)
- Simplify moving expenses to benefit more HSS providers, especially in rural and Greater Minnesota areas, where there are not as many qualifying settings required on both ends of an individual's move

Changes to eligible billing activities would require amendment to authorizing MN Statute language, as well as DHS and CMS negotiation and approval, as well as reconsideration on type of federal authority.

Conflict of Interest

As a federal requirement of the 1915(i) authority for HSS in Minnesota, evaluation and assessment of eligibility for individuals must be conducted independently from provider agencies of the Housing Transition or Housing Sustaining services. The intent of these policies is to prevent situations where providers or organizations have financial interests that could compromise the quality of care to recipients by performing both assessment and service roles. Exceptions to this separation can be considered and approved in two situations:

1. The provider is the only willing and qualified provider in a certain geographic area of the state where there is a provider shortage, as determined by the Department; as named on www.mn.gov/dhs, and
2. The provider is the only willing and qualified provider with experience and knowledge to provide services to individuals who share a common language or cultural background.

These federal requirements align with Home-and-Community-Based services available for people with disabilities in Minnesota. But they do not align with other federal requirements found in Behavioral Health services, such as the recent shift to Direct Access for people receiving Substance Use Disorder services. Direct Access allows an individual to choose where and who provides their assessment for eligibility as well as choose the provider and level of care they receive. For people experiencing homelessness, engagement and

> *"Why do I have so many different workers and have to go to so many places to tell my story to get help? I don't know them, and they don't know me…"*
>
> Person with Lived Experience

relationship-building is a critical component of service delivery. Feedback from communities who provide both models (conflict of interest separation and direct access), as well as people with lived experience who report on their preference, indicate the direct access model is highly preferable as it involves fewer professional relationship handoffs.

Under a 1915(i) authority, stakeholders would like to see homelessness recognized as eligible for the second exception named above, as a group with unique cultural background due to the social context and conditions surrounding homelessness, as evidenced by peer reviewed research. Alternatively, shifting to an 1115 waiver would not require the conflict-of-interest policy.

Provider Eligibility

Provider Enrollment

Since 2020, as providers were enrolling in Minnesota Health Care Programs (MHCP), there have been different methods available to do so. At times, providers were encouraged to fax their Provider Enrollment forms to DHS and at other times they were recommended to enroll via the DHS provider enrollment portal online. Providers report varying success and challenges with both. When HSS launched in July 2020, it was during the early months of the COVID-19 pandemic and many business operations were disrupted. Most staff were working remotely and communication via regular mail service was not always received when public-facing offices closed. In addition, providers frequently reported evidence that documents were faxed to DHS, but later reported as missing. This was one of several delays to successful provider enrollment in HSS. Many providers faced more than a year to complete provider enrollment for some or all of their service locations.

Stakeholders request increased DHS capacity to support the provider enrollment process from beginning to end. With more training and information available, providers seek to talk with someone to ask questions and describe their situation. They want to reduce wasted time of back-and-forth emails (and "snail mail") delaying successful enrollment.

Site-Based Fees

Another challenge frequently mentioned by stakeholders is the provider enrollment fee required for each "provider-controlled" site of HSS services. This fee is required in MN Statute 256B.04, subdivision 21 and described on the MHCP website. Federal regulations (Code of Federal Regulations, title 42, section 455, subpart E) also require this nonrefundable provider application fee of $709 per location or housing site (as of January 1, 2024) to cover "institutional providers of medical or other items or services or suppliers" to fund provider screening costs. In this case, the term "institutional provider" is used differently than in other MHCP contexts. DHS considers any provider with a tax identification number (TIN) or federal employee number (FEIN) to be an institutional provider. In supportive housing, many nonprofits provide HSS at multiple site-based locations and may be responsible for several thousands of dollars in provider enrollment fees at application and at revalidation (at least every five years). This is reported as burdensome, especially during an unprecedented industry financial crisis among supportive housing providers.

Recognizing the unlikely lift to change federal requirements in addition to MN Statute, solving this barrier could require consideration of another type of federal Medicaid authority, such as an 1115 waiver.

Individual Eligibility

Individual eligibility criteria for a person to receive HSS include the following:

- Age and Medicaid Eligibility:
  - Recipients must be 18 years or older
  - They must meet the eligibility criteria for an approved group under Minnesota's Medicaid Plan
  - Financial eligibility criteria must also be met
- Disability or Disabling Condition:
  - Meet the aged, blind, or disabled criteria as described under Title II of the Social Security Act
  - Have an injury or illness expected to cause extended or long-term incapacitation
  - Have a diagnosis of mental illness or developmental disability (or related condition)
  - Have a diagnosis of mental health condition, substance use disorder, or physical injury requiring a residential level of care, and is transitioning to the community
  - Determined by the lead agency to have a learning disability
  - Have a diagnosis of substance use disorder and be enrolled in a treatment program or on a waiting list
- Housing Instability:
  - Homeless (lacking a fixed, adequate nighttime residence)
  - At risk of homelessness (e.g., facing eviction notices or rent/utility payment arrears)
  - Transitioning from an institution or licensed or registered setting
- Needs-Based Functional Criteria:
  - Require assistance in at least one of the following areas due to disability, long-term condition, or age:
    - Communication
    - Mobility
    - Decision-making
    - Managing challenging behaviors

Verifying Eligibility

To verify eligibility, providers must submit documentation showing need assessment, proof of disability, and completion of a person-centered plan. However, the complexity and volume of paperwork pose challenges for both providers and individuals. For homeless individuals, the Professional Statement of Need (PSN) is a common verification method. Some communities have designated professionals to sign PSN forms, but they often face overwhelming requests. Mental health providers and other medical professionals frequently hesitate to sign unless there's an established therapeutic relationship due to perceived risk and confusion about the form's purpose.

Stakeholders suggest finding ways to use presumptive eligibility criteria based on information already known to DHS and/or MCOs. For example, many people have verified disability or disabling conditions for other state or federal programs such as Housing Support, Behavioral Health Services, MFIP Family Stabilization Services, or even a disability basis of eligibility for Medical Assistance.

Other states, such as Massachusetts and Arizona, found ways for the state and MCO partnerships to supply known information to verify eligibility criteria into a centralized database behind the

scenes, reducing the administrative burden for providers and state agency staff to complete and process individual applications under 1115 waiver authorities.

Eligibility Determinations

Individual eligibility is determined by a team of staff at DHS. Providers upload eligibility documentation into a web-based portal for their review. Timelines for approval since HSS was implemented in July 2020 have varied and frequently are more than eight weeks. Providers report large amounts of uncompensated time spent serving individuals as a result, and many have received notice from DHS to resubmit all documentation after an initial three-month period has passed without eligibility approval or denial. Many providers report applications were denied for simple things, like not checking a box or a typo. In some cases, housing opportunities were lost or denied because service approval was not yet authorized.

Providers suggest possible improvements to accelerate application processing, including development of online applications, which could ensure all criteria and documentation are satisfied. For example, an online form could prevent submission if there are errors or missing information.

> *"We've had more than 40 names waiting for approval for more than two months. If we don't hear back soon, we won't have time to fix any changes we need to make before the 90-day deadline. We'll have to resubmit everything and lose funding for services for that whole time. We can't keep doing this."*
>
> HSS Provider

DHS staff report the need for additional staff capacity to expediate eligibility processing. Temporary efforts to direct staff resources from other areas of DHS or offer flexibility for overtime have proven helpful, but not sustainable or ongoing. Issues of eligibility processing have resulted in some providers choosing to discontinue provision of HSS services.

Eligibility Visibility

Individuals and HSS providers report lack of clarity about individual HSS eligibility or approval status. They express the need for a straightforward method to verify this information. DHS recommends that individuals directly contact the MCO responsible for their healthcare if they are unsure about their HSS enrollment. However, navigating this process remains challenging, and some report that MCOs have been uncertain or unable to answer their questions.

For people experiencing homelessness, it is common to frequently move around to survive and they may be unable to stay in close contact. Or, in cases like those described in the Quality Assurance section below, the individual is identified as eligible by Housing Consultation providers, but unaware of their approval status. Individuals report a lack of transparency and flexibility around changing providers. Some participants report not knowing they had an HSS provider, and/or not being able to easily change providers if they would like to.

Stakeholders suggest expanded capacity for DHS to support requests to confirm HSS eligibility and provider assignment, with procedural clarity on how individuals can transfer to a provider of choice. Another example can be found in Arizona, where they created a centralized database with a portal for authorized users to look up information about individual eligibility and provider coverage.

Billing and Payment Structure

Providers who serve people experiencing homelessness face challenges when budgeting for HSS reimbursement. The unpredictable nature of interactions with transient individuals without stable housing makes consistent planning difficult. Most providers report that none of the available service funding programs, even braided together with HSS, pay enough to support their service staffing needs.

Rates

The federally authorized reimbursement rate for HSS services are as follows:

- Housing Consultation: $174.22 per session (single billable unit)
- Housing Transition: $17.17 per 15-minute unit of service (requires minimum of 8 minutes)
- Housing Sustaining: $17.17 per 15-minute unit of service (requires minimum of 8 minutes)

While the reimbursement rates are consistent or even higher than similar services in other states, among supportive housing providers in Minnesota, a majority report it needs to be higher to cover actual costs. Some MCOs have independently raised the reimbursement rate (Prime West and BCBS).

> *"We need a higher service rate so we can hire staff and serve more people. This is a program people stay in, so there is little turn over in caseloads. But it doesn't pay for 1FTE without a second funding source."*
>
> HSS Provider

Billing Increment

The most frequent feedback related to billing and payment pertains to the 15-minute increment billing structure. As other states have discovered, this structure does not work well for supportive housing providers serving people experiencing homelessness. Both site-based and scattered-site providers report that the administrative burden on staff to use 15-minute increment billing is disruptive to engagement and productive service provision. Especially during the current industry staffing crisis, it is difficult to train and implement processes to support this level of fine-tuned time tracking.

Stakeholders universally call for a change to either a daily or monthly billing increment to ease administrative burdens. This change would more closely align with the billing structure of many other Medicaid services in Minnesota.

Managed Care Organizations

Of the Home and Community-Based Services (HCBS) in Minnesota, HSS is unique in its requirement for all contracting (or other formal authorization) and billing through MCOs as part of the 1915(i) State Plan. Other HCBS programs include more "Fee-for-Service" with direct billing through the Minnesota Health Care Programs (MHCP).

Several years before CMS negotiation, DHS anticipated that HSS might also be administered as Fee-for-Service. To help service providers who serve people experiencing homelessness to prepare, DHS used a major change to the state's Housing Support program as an opportunity to train hundreds of providers in how to directly bill Fee-for-Service to MHCP using the MNITS state billing system. Later, HSS was designed differently to flow through MCOs under a 1915(i) State Plan. While

this could provide a platform for broad reach and impact across Medical Assistance recipients in Minnesota, it has created barriers for several organizations to get into the work.

> *"The financial model with the current reimbursement rate is a challenge. We are also generally new to MA-billable services and need more infrastructure and TA support to roll out HSS in a sustainable, feasible way."*
>
> HSS Provider

Many service providers in Minnesota with experience serving people who are unhoused are also long-time licensed Behavioral Health service providers. This means they have established medical billing systems in place and experience leveraging other Medicaid services. However, even within Medicaid-experienced organizations, for many staff who historically provided services for people experiencing homelessness, Medicaid resources and processes were new and challenging. For others without this infrastructure, establishing new business relationships and medical billing infrastructure with multiple MCOs can be confusing and cost prohibitive.

All providers enrolled with HSS must submit individual application materials to DHS for approval, but billing for each individual goes through the specific MCO serving that person in their geographic area. Each MCO has their own unique billing infrastructure and requirements, and potentially unique rate as well. This means providers must use multiple interfaces, between DHS and each MCO in their region in order to successfully bill and receive payment for HSS.

Since 2020, stakeholders have consistently requested third-party administrator services to simplify and streamline their billing processes across MCOs. Other states (e.g., Arizona and Massachusetts) have models that partner with MCOs and do not require contracts or billing to pass-through MCOs but include centralized billing and payment systems for the state under an 1115 federal authority.

Housing Support Rate Reduction

Minnesota's state-funded Housing Support program has been a primary service funding source for site-based and scattered-site supportive housing programs as a long-term solution to homelessness in Minnesota for more than a decade. Many site-based supportive housing units funded through Minnesota Housing use Housing Support funds to pay for room and board (rent and operating) as well as supplemental services to pay for required support services.

MN state law established a full Housing Support supplemental service rate at $482.84 per person per month in July 2020 through December 2023 and increased to $494.91 per person per month in January 2024. Viewed another way, supplemental services today pay $16 per person per day at the full rate.

Attachment D shows a crosswalk between Housing Support supplemental services and HSS. The green and blue columns represent services in the HSS. The beige column represents the MN Housing Support Supplemental Services. The yellow highlighted Housing Support service, "Tenancy Supports," is an umbrella that encompasses the potential overlap with HSS. However, state law allows Housing Support providers to provide supplemental services directly or they can refer individuals to an entity that does, which would mirror a case management function, and not be considered duplicative of a housing service function. There is not a broad brush to assume or know how providers approach the work for each individual other than documentation in case notes.

In the 2017 Legislative Session, the Governor's budget proposal included a package of initiatives from DHS related to "Individual Community Living." It included several housing-related items, including language in MN Statute to authorize Minnesota to pursue Medicaid funding for Housing Stabilization Services (HSS) and intending to reduce the state-funded Housing Support supplemental service rate for individuals by 50 percent if they were determined eligible for HSS:

MN Statutes 256B.051 HOUSING STABILIZATION SERVICES

Subd. 7. Housing support supplemental service rates. Supplemental service rates for individuals in settings according to sections 144D.025, 256I.04, subdivision 3, paragraph (a), clause (3), and 256I.05, subdivision 1g, shall be reduced by one-half over a two-year period. This reduction only applies to supplemental service rates for individuals eligible for housing stabilization services under this section.

This rate reduction potentially applies to nearly 5,000 individuals (including individuals with children) with disabling conditions and long histories of homelessness receiving state Housing Support supplemental services in lease-based supportive housing settings in the community. The original intent of the rate reduction was to help maximize federal resources, serve more people and increase capacity without overall revenue loss to providers. It was to be gradually implemented over a two-year period, with every Housing Support provider serving people in supportive housing facing an automatic and permanent rate reduction by the end of the two-year period.

In January 2020, Housing Support providers brought concerns to DHS and the MN Legislature about the potential negative effects of a uniform rate reduction with the upcoming HSS implementation. They noted that HSS eligibility varied from Housing Support, so HSS revenue could not be assumed for every situation, potentially leading to significant revenue loss. There was also concern that individuals might be pressured into applying for HSS to secure provider funding, not for individual benefit. Prior to the July 2020 HSS rollout, DHS General Counsel confirmed that rate reductions would be limited to approved individual HSS applications, not a general cut.

For individuals who chose to terminate their HSS benefits before their one-year eligibility span (which applies to every person approved for HSS), DHS also determined that MN Statute would not allow their rate to return to full until their annual recertification date, even if they were unaware an application was submitted on their behalf (see Quality Assurance below). They could refuse and terminate the HSS service but could not restore their Housing Support supplemental service rate.

Making matters more complex, due to a misunderstanding, the Minnesota Revisor's Office and DHS inadvertently repealed language about the Housing Support rate reduction from legislation, effective August 2023, which

> *"Even the full monthly rate for Housing Support Supplemental Services does not begin to cover our costs to provide supportive services for people transitioning out of homelessness. The reduced half rate is completely untenable; thus, our agency cannot afford to accept new referrals for people enrolled in HSS. As a result, unhoused community members who are most in need of housing opportunities are denied housing. The people who would most benefit from supportive services due to high acuity needs are the same people currently denied due to unsustainable service funding. Ironically, this is the target population for HSS and why it was implemented in the first place."*
>
> Housing Support Provider

remained unnoticed until December 2023. Stakeholders lobbied for the restoration of the full rate, engaging with state leaders and the Governor's office. DHS retroactively reversed the repeal at the end of the 2024 legislative session, attributing their decision to a technical position rather than policy disagreement. Stakeholders, having advocated for this issue before the oversight, continue to seek a resolution in the 2025 session.

An unintended consequence of this rate reduction is that supportive housing providers report they are choosing between HSS and full Housing Support supplemental service rates. Many have decided not to enroll their clients in HSS because they would no longer have enough funding to maintain minimum service levels. Additionally, housing providers are reducing or eliminating their availability for people already enrolled in HSS. This means some people no longer have access to a significant path out of homelessness in Minnesota.

Tribal Encounter Rate

Tribal health care systems are authorized by the federal government to provide their own health care services and bill Medicaid at a Tribal Encounter Rate set by the Office of Management and Budget. The Tribal Encounter Rate is reimbursed at 100% by the federal government, with no required state contribution. The State of Minnesota determines the scope and requirements of what services may be eligible under a tribal encounter rate. Housing-related services are not currently included as an approved category under Minnesota's State Plan Amendment.

Access and effectiveness of services is urgent, as homelessness and health disparities are disproportionately higher for Native Americans in Minnesota. The Wilder Research Center's "Minnesota Homeless Study Issue Brief" released in June 2024 reports that 30 percent of people experiencing homelessness in Minnesota are Native American, and are 28 times more likely to experience homelessness than non-Latino whites according to news reports at the release of the State's "Crossroads to Justice Plan: Minnesota's New Pathways to Housing, Racial and Health Justice for People Facing Homelessness." American Indian people experiencing homelessness had a rate of death one-and-a-half times higher than others experiencing homelessness and five times higher than the general population, according to a report from the Minnesota Department of Health and the Hennepin Healthcare Research Institute released in 2023.

The Minnesota Tribal Collaborative, consisting of staff from nine Minnesota tribes (Bois Forte, Fond du Lac, Grand Portage, Leech Lake, Lower Sioux, Mille Lacs, Red Lake, Upper Sioux, and White Earth), along with many advocates and organizations across the state, have called for a State Plan Amendment to add Housing Services to the Tribal Encounter Rate (see Attachment E). This would allow increased and more streamlined federal reimbursement for tribal health programs to provide life-saving housing-related services.

Quality Assurance

Training on Housing and Service Models

Community members receiving and providing emergency and long-term solutions for people experiencing homelessness frequently report misunderstandings among many HSS providers about housing and service models. For example, several people with lived experience reported referrals from HSS providers to higher levels of care than necessary, including licensed residential facilities for people with disabilities, instead of to community-based rental settings. They were told

that settings like adult foster care or boarding care homes were the only options available to meet their housing needs. Neither of these settings would qualify for a person to receive HSS sustaining services ongoing. Individuals report these referrals are most often made by providers with experience in traditional disability services (HSS replaced a long-time HCBS waiver service called Housing Access Coordination). Some individuals said referrals to residential facilities caused them to give up their housing search, and others eventually found assistance from providers more familiar with community options. Some individuals reported moving into higher level care facilities and found them to not be a good fit.

Confusion about Funding Integration

In many situations, a person eligible for or receiving HSS is also eligible for or receiving other resources to support their needs. It is important for providers to have clarity on the policy interactions between these resources, so they remain in compliance with program requirements and do not risk duplication or ineligibility when combined. Stakeholders report government programs often state concerns about duplication of funding activities across funding sources, but do not recognize realities of funding amounts needed to meet individual needs in a sustainable way. Most providers say they must integrate funds to do so.

Providers report years of seeking clarity on some of these interactions, without resolution. Many providers reported receiving conflicting or confusing guidance from DHS to questions around eligibility, documentation, and allowable activities. Policy staff across various federal, state, and local resources have different interpretations and understanding of restrictions on resource braiding, which causes confusion and, in some cases, discontinuation of service provision to avoid unknown risk.

Predatory Enrollments

Many homeless services programs, including emergency shelters, drop-in centers, and supportive housing, report routine predation in and around their spaces by HSS consultation providers misrepresenting what they offer participants. Individuals report being approached on the street and promised housing. In some cases, organizations report that HSS providers have fraudulently worn nametags in or near their settings to indicate they work with a trusted organization, but they do not. In another example, a service provider described having to add security to their setting to keep the predatory HSS providers away. County staff in all corners of the state report spam-level emails from HSS housing consultation providers trying to generate business.

Many HSS consultation providers operate ethically and are very skilled, but predatory enrollments in HSS are increasingly common. This leads to challenges in obtaining housing and services, switching providers, or choosing preferred ones. A significant issue arising from such enrollments is a 50 percent cut in state-funded Housing Support (see Housing Support rate reduction above) for people with disabilities, disrupting their current services.

Centralized Reporting and Response

Whether wanting to ask process or policy questions, inquire about provider enrollment or individual application status, report issues around program integrity of a provider, or predatory enrollment activities, stakeholders are not clear about how or where to reach out for timely response. There are frequent calls for increased DHS capacity to talk with stakeholders when they have questions or concerns, as well as frustration when referred to websites that they struggle to navigate.

Components of HSS implementation are complex, spread among different administrations and divisions at DHS, including the Health Care Administration (e.g., Provider Enrollment, MCO contracting), the newly created Homelessness, Housing, and Support Services Administration (HSS policy and eligibility determination), and the Office of Inspector General (Program Integrity, Maltreatment Investigations). DHS does maintain a general email for HSS policy questions, but staffing capacity is a challenge to respond timely. HSS does not share the infrastructure other Medicaid services have at DHS for response and investigation into reports of fraud or other program integrity issues.

Attachment A

HSS Stakeholders Feedback

Enrolled Providers

Most providers surveyed had previous experience billing Medicaid funding for other services, and most agencies had experience providing services for people with disabilities. Their main points of feedback included:

- Clarity and agreement among government policy staff needed about Housing Stabilization Services integration with homeless-specific funding (e.g., HSASMI, LTHSSF, HUD, and Housing Support).
- The length of time for DHS to complete applications and renewals is too long.
- Providers need a way to find out if a referred participant is already determined eligible for HSS and who may already be assigned as their HSS provider.
- Billing complexities and payment delays had major negative impact on utility of services.
- The HSS Conflict of Interest policy is a barrier for people experiencing homelessness and must be permanently removed.

Providers Not Enrolled

Most of the providers in this group had limited or no experience billing Medicaid funding or working with MCOs, but did have experience providing emergency homeless response services, permanent supportive housing, and were using state Housing Support resources to do so. Their main feedback included:

- Frustration that the initial implementation of HSS was too complicated, difficult, and slow. (Many providers were still waiting to get through the DHS provider enrollment process and MCO contracting/authorization two to three years after the service was implemented.)
- Funding levels did not support the additional staffing needed to implement.
- Concern that implementing HSS would lead to overall financial losses.
- Concern that the HSS Conflict of Interest policy was not trauma-informed or person-centered, and generally not recognized as a benefit that added value.

Top Four Topics of Interest for Statewide HSS Meetings

1. How to work together to advocate for HSS rate increases
2. Simplification of HSS integration with housing and homelessness response system funding
3. Legislative advocacy planning
4. Regular DHS system changes information and updates

Least Popular Topics of Interest for Statewide HSS Meetings

- Technical assistance for DHS provider enrollment
- Forums to hear other providers' experiences with HSS (too many with that focus and HSS TA team office hours could cover)

Results from February 2022 Survey (28 organizations)

- 57 percent name HSS a high priority for their organization, with 25 percent naming it as the top priority.
- Question: What could make HSS more useful for your organization?

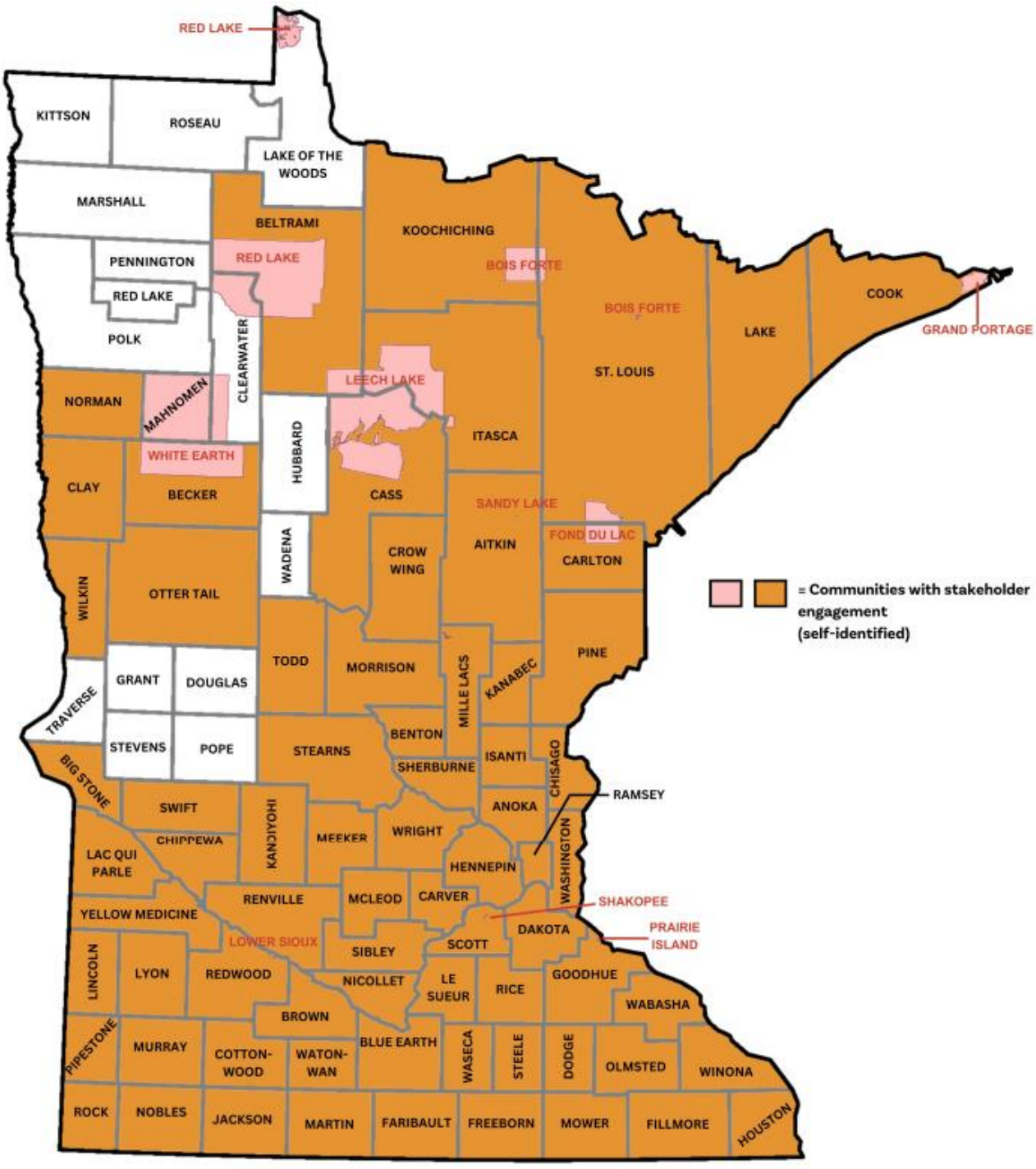
#	RESPONSES
1	The split of providers does not work in the homeless community and is the opposite of person-centered. Could there be a permanent waiver for LTH participants?
2	Permanent change to the conflict of interest.
3	Connecting those the county interacts with for on-going housing services and supports.
4	If billing was centralized and made more efficient.
5	Increasing the rate so that it can be used as a stand alone service, rather than a supplement to other funding; making the rate for housing support not cut in half for those coming to us enrolled in HSS - having someone on HSS and Housing Support has proven to give us a deficit in funding that is not sustainable, based on 7 months of data. We could really use this to increase housing outcomes, hire staff at better wages, if we had housing support service rate plus the HSS supplemental rate as possible.
6	Client buy-in. The client understanding how enrolling in this service will benefit them--it seems that we understand it, but the client experiences no visible/immediate "output." Also, if we could do our own consults. Finding a consult provider and scheduling an enrollment with folks struggling with homelessness is very difficult with a high no show rate.
7	Faster approval time for eligibility. Medical billing - companies better understanding what HSS is, client information to be correct across platforms, etc.
8	Streamline administrative complexities. Funding sources and conflicting compliance matters continue to threaten the viability of organizations working to serve people in need. Funding for back-office support is needed, or collaborations to handle the administrative side, so people and agencies can fulfill their core purpose of serving would be appreciated, as these challenges impact direct service staff, program supervisors/directors, finance/hr departments, and ultimately can translate into an increased amount of time on paperwork, instead of relationship building which is central to our work.
9	There needs to be a liaison for each MCO that can assist with billing. I'm still trying to get paid from the client I moved today, 2/17/22. I have been working for her since December and I have not been paid anything! More people processing Eligibility Letters. It's taking about 8 weeks to process letters. That's too long.
10	The rate needs to be financially sustainable.
11	The billing process becoming more fluid
12	Removing the conflict of interest and some of the eligibility results
13	A higher service rate so that we can hire more staff and provide more people with this service. This is a program people stay in. So there is little turn over in case loads. But it doesn't pay for 1FTE without a second funding source.
14	Right now we have yet to implement HIPAA and that is a big reason we have not billed - it is time and resource consuming and we have yet to know what additional technology costs will be involved. Additionally, in COVID, billable hours are low and don't make up the Housing Support rate cut. We are exploring how to make the PSN and Housing Consultation more person-centered for our participants. We also need to figure out how to brain HSS funding with HUD CoC and HSASMI funds for our Family Supportive Housing programs.
15	For my program, it would be more useful if we could bill for it for our clients who also have HUD Housing Supports, maybe even also TCM.
16	Providing a template to conduct a cost/benefit analysis of utilizing this funding stream. Clear guidance on the impact of this funding stream on Housing Supports. We were told that our

	Housing Supports payments would not be reduced because of the availability of this funding stream, but it seems they actually have been.
17	Loosening the enrollment timeline and systems that impact long wait times for homeless people to actually be able to benefit from the services.
18	Timely responses from DHS on applications/renewals. More accurate alignment of the date ranges for Eligibility and Plans. More timely alignment and communication of SALs (Housing Supports) with HSS eligibility. Being able to see in MN-ITs if a client is already eligible for HSS and who the Services Provider is.
19	The financial model with the current reimbursement rate is a challenge. We are also generally new to MA-billable services and need more infrastructure and TA support to roll out HSS in a sustainable, feasible way.
20	Easier enrollment and higher reimbursement
21	Easier enrollment process/less time from plan submission to enrollment. Timeline for DHS approval is too long. Higher rates. Ability to refer internally - Many clients do not want another different provider and forcing them do do so to get services is not person centered or trauma informed. Ability to bill or retro bill while waiting for an updated plan to be approved - currently, there is no ability to bill if for some reason an updated person centered plan is not approved right away. This will either cause a gap in services for the client or a gap in payment for the agency and neither is a good option. Timeline for DHS approval it too long.
22	[redacted] has applied for but is not currently billing for HSS
23	So we are currently wrapping up week seven, yes seven, for some folks still pending approvals for HSS services from DHS. It is taking so long for people to get approved, sometimes people lose housing options or subsidies because we can not get the approval letters and services started soon enough for them.

	NOT TRUE	SOMEWHAT TRUE	TRUE	VERY TRUE	N/A	TOTAL
We have the technology and infrastructure needed to successfully implement and provide HSS.	10.71% 3	17.86% 5	28.57% 8	39.29% 11	3.57% 1	28
We have previous experience working with Managed Care Organizations.	32.14% 9	3.57% 1	28.57% 8	32.14% 9	3.57% 1	28
We understand and have the information needed to integrate HSS with our existing funding, e.g., HUD, Housing Supports, TCM, HASAMI, Private Foundation grants, etc.	17.86% 5	32.14% 9	35.71% 10	14.29% 4	0.00% 0	28

Attachment B

Community Conversations on Long-Term Solutions to Homelessness



Attachment C

Hearth Connection Intermediary Role

Hearth Connection contracts with the following entities to provide funding, training, and oversight of support services and/or rental assistance for people experiencing homelessness in Minnesota:

Northeast Region

Nonprofit Organizations

- Arrowhead Economic Opportunity Agency (AEOA)
- Center City Housing
- Human Development Center (HDC)
- Life House
- North Shore Horizons
- Northland Counseling Center
- Range Transitional Housing

Tribal Nations

- Bois Forte Tribal Government
- Fond du Lac Human Services

Central Region

Nonprofit Organizations

- Central MN Mental Health Center (CMMHC)
- Lakes and Pines Community Action Council
- Lutheran Social Service of MN (LSS)
- New Pathways
- Tri-County Action Program

Metro Region

Nonprofit Organizations

- Amherst H. Wilder Foundation
- Avivo
- Breaking Free
- Clare Housing
- Common Bond
- Guild Incorporated
- Interfaith Outreach and Community Partners (IOCP)
- Jeremiah Program
- Lutheran Social Service of MN (LSS)
- People Incorporated
- Phia T Xiong and Jeff D Spencer Foundation (aka Handy Help)
- Project for Pride and Living (PPL)
- Scott Carver Dakota Community Action Program
- Simpson Housing
- Streetworks Collaborative
- The Link
- YouthLink

Southeast Region

Nonprofit Organizations

- South Central Human Relations Center (SCHRC)
- Zumbro Valley Health Center

County Municipality

- Blue Earth County Human Services

HSS Feedback from Hearth Connection Contracted Network

Providers Using HSS

Five supportive housing providers serving people experiencing homelessness are currently providing HSS.

- Provider 1: Billing but struggle with delays on eligibility determinations.
- Provider 2: Very successful billing, but struggle with delays on eligibility determinations.
- Provider 3: Minimal use. Housing Support rate reduction is a barrier. Not planning to expand.
- Provider 4: Minimal use. Not planning to expand.
- Provider 5: Administration is major burden. Needed to hire full-time coordinator to track applications, MCOs, billing and payment issues. Current billing revenue is reduced by half, due to combination of staff turnover and slow eligibility determinations.

Providers Not Using HSS

20 supportive housing providers serving people experiencing homelessness are not providing HSS.

- Provider 6: Enrolled, but not billing. Administrative burden is too high.
- Provider 7: Enrolled, but not billing. Administrative burden is too high.
- Provider 8: Enrolled, but not billing. Rates are too low and administrative burden is too high.
- Provider 9: Enrolled, but not billing. Rates are too low and administrative burden is too high.
- Provider 10: Enrolled, but not billing. Rates are too low and administrative burden is too high.
- Provider 11: Enrolled, but not billing. Will bill if unit changes to daily or monthly.
- Provider 12: Enrolled, but not billing. Will bill if unit changes to daily or monthly.
- Provider 13: Enrolled, but not billing. Stopped after delays with eligibility processing.
- Provider 14: Enrolled, but not billing. Stopped due to payment structure and delays with eligibility processing.
- Provider 15: Enrolled, but not billing. Stopped using due to payment structure, rates are too low, and delays with eligibility processing.
- Provider 16: Enrolled, but not billing. Trying to build infrastructure to manage administrative complexity.
- Provider 17: Enrolled, but not billing. May reconsider if simplified.
- Provider 18: Not enrolled. Duplicative of other funding and administrative burden too high.
- Provider 19: Not enrolled. May reconsider if simplified.
- Provider 20: Not enrolled.
- Provider 21: Not enrolled.
- Provider 22: Not enrolled.
- Provider 23: Not enrolled.
- Provider 24: Not enrolled.
- Provider 25: Not enrolled.

Unknown Use of HSS

Six supportive housing providers serving people experiencing homelessness are enrolled to provide HSS with unknown usage.

Attachment D

Crosswalk Between MN Housing Support Supplemental Services and MA Housing Stabilization Services

1	HOUSING STABILIZATION SERVICES: Housing Transition	2	HOUSING STABILIZATION SERVICES: Housing Sustaining	3	HOUSING SUPPORT: Supplemental Services
			↓ General definition (MN 256I.03, subd. 8), "including, but not limited to..."		↓ These are on the Professional Statement of Need. Need at least two. ↓
a	Developing a housing transition plan*	a	Developing, updating and modifying the housing support and crisis/safety plan on a regular basis	a	Oversight and up to 24-hour supervision
b	Supporting the person in applying for benefits to afford their housing, including helping the person determine which benefits they may be eligible for*	b	Preventing and early identification of behaviors that may jeopardize continued housing	b	Medication reminders
c	Assisting the person with the housing search and application process*	c	Educating and training on roles, rights, and responsibilities of the tenant and property manager	c	Assistance with transportation
d	Assisting the person with tenant screening and housing assessments*	d	Transportation with the person receiving services present and discussing housing related issues	d	Arranging for meetings and appointments
e	Providing transportation with the person receiving services present and discussing housing related issues	e	Promoting/supporting cultural practice needs and understandings with landlords, property managers and neighbors*	e	Arranging for medical and social services
f	Helping the person understand and develop a budget	f	Coaching to develop and maintain key relationships with property managers and neighbors	f	Tenancy supports to assist an individual with finding their own home, landlord negotiation, securing furniture and household supplies, understanding and maintaining tenant responsibilities, conflict negotiation, and budgeting and financial education
g	Helping the person understand and negotiate a lease	g	Advocating with community resources to prevent eviction when housing is at risk and maintain person's safety*	g	Supportive services to assist with basic living and social skills, household management, monitoring of overall well-being, and problem solving
h	Helping the person meet and build a relationship with a prospective landlord	h	Assistance with the housing recertification processes*	h	Employment supports to assist with maintaining or increasing employment, increasing earnings, understanding and utilizing appropriate benefits and services, improving physical or mental health, moving toward self-sufficiency, and achieving personal goals
i	Promoting/supporting cultural practice needs and understandings with prospective landlords, property managers*	i	Providing in-service transportation (person must be with)	i	Health supervision services to assist in the preparation and administration of medications other than injectables, the provision of therapeutic diets, taking vital signs, or providing assistance in dressing, grooming, bathing, or with walking devices
j	Helping the person find funding for deposits*	j	Continued training on being a good tenant, lease compliance, and household management		
%	Helping the person organize their move*	k	Supporting the person to apply for benefits to retain housing*		
l	Researching possible housing options for the person*	l	Supporting the person to understand and maintain/increase income and benefits to retain housing*		
m	Contacting possible housing options for the person*	m	Supporting the building of natural housing supports and resources in the community including building supports and resources related to a person's culture and identity		
n	Identifying resources to pay for deposits or home goods *	n	Working with property manager or landlord to promote housing retention*		
o	Identifying resources to cover moving expenses*	o	Arranging for assistive technology*		
p	Completing housing applications on behalf of the service recipient*	p	Arranging for adaptive house related accommodations.*		

Attachment E

Tribal Encounter Rate

NORTH STAR POLICY CONSULTING CSH Ei-Consultants MESH

Recommendation: Add Housing Services Category

Recommendation

Services billed to Medicaid by tribal health care organizations **are covered by the federal government at 100%**. States should be eager to work collaboratively with tribal health care programs to eliminate barriers and rapidly increase tribal health services.

Through our conversations with tribal leaders, **we recommend the addition of a new category called "Housing Services" through a State Plan Amendment**. This addition would allow tribal health programs to provide Housing Stabilization Services at the **Office of Management and Budget (OMB) tribal facility encounter rate, as opposed to the current 15-min unit rate.** Furthermore, it would allow for the option to provide any future Medicaid-funded housing-related services at the encounter rate.

Background:

Housing Stabilization Services (HSS) is a Medicaid-funded benefit that began in Minnesota in July 2020. The purpose of the program is to improve the health and well-being of people with disabilities by addressing barriers to stable housing.

Services like those provided through Housing Stabilization Services (HSS) can make the difference between just a place to live and long-term stability and health.

Housing Stabilization Services can help people with disabilities and seniors:

- **Successfully transition** to stable housing by helping with the housing search and application process, resolving barriers to accessing housing and assisting with accessing other resources and supports; and
- **Maintain long-term housing** by creating a stable housing plan, supporting key relationships with property managers and neighbors, preventing eviction, and building natural housing supports.

Demand for Housing Stabilization Services providers has surpassed initial expectations. As of May 2022, DHS reported that **9,349 individuals were enrolled** in Housing Stabilization Services and receiving services. This is 77 percent more than projected. In addition, as of November 2022, 553 sites enrolled, including three tribal organizations located on the White Earth, Red Lake, and Bois Forte reservations.

American Indian Housing Disparities

- Based on the 2018 Wilder Research Center's Reservation Homeless Study in Minnesota, 2,315 people across six Ojibwe tribal nations were counted as homeless or near homeless. Of all respondents counted, 25% were parents accompanied by their children and 7% were Elders over the age of 55. Most respondents (77%) met the Minnesota definition of long-term homelessness.

- According to the Minnesota Department of Corrections 2022 Homelessness Mitigation Plan, 1,128 (25%) of releases in 2021 from a Minnesota prison were released to sheltered or unsheltered homelessness. Of the 1,128 individuals released to homelessness from prison, almost 10% identified as Native American, yet are only 1.1% of the population in Minnesota.
- Given the disparities of American Indians in both the homeless population and people living in healthcare institutions, it is imperative that Housing Stabilization Services are readily available through tribal health programs.

Tribal Healthcare

There is a long, complex history of treaties, laws, and court decisions that culminate in the federal government's "trust" responsibility to protect tribal health care. Federal responsibility for health care for Native Americans was codified with the Snyder Act of 1921, which authorized federal funding to federally recognized tribes for health care services. The Snyder Act identified the "relief of distress and conservation of health of Indians" as a federal function. For understandable reasons there is mistrust of federally provided health care services. In the 1970s, many steps were taken to restore Indian sovereignty and strengthen the failed trust relationship that the federal government had with tribal nations. In 1987, the United States Congress enacted the Indian Healthcare Improvement Act (IHCIA), which was permanently reauthorized in the 2010 Affordable Care Act. IHCIA authorizes tribes to provide their own health care services and bill Medicaid at the Office of Management and Budget (OMB) tribal facility encounter rate.

Current Categories

The State of Minnesota determines Medicaid reimbursable tribal services through State Plan Amendments, which describe service requirements, licensure requirements, documentation, etc. These State Plan Amendments also lay out services that would be eligible for the OMB tribal facility encounter rate. **Currently approved categories include:**

- Ambulance
- Dental
- Mental Health
- Home Health
- Medical
- Pharmacy
- Telemedicine
- Alcohol and Drug Abuse Services

Benefits

There are several benefits to adding Housing Services as a tribal encounter rate category:

- **Increased Funding for Tribes:** Additional funding will enable Tribes to expand housing resources on and off reservations.
- **Cost Savings for The State of Minnesota:** tribal health services are reimbursed at 100% by the federal government, meaning there is no fiscal cost to the State of Minnesota.
- **Federal Government Fulfills its Trust Responsibilities:** The tribal encounter rate reimbursements will ensure the United States Government meets their trust responsibilities to Tribes for Healthcare and Housing.
- **Surplus Revenue for Housing Development:** By adding a Housing Services encounter rate category, Tribes will have a new funding source for future supportive housing developments to serve tribal members.

Bois Forte Fond du Lac

Minnesota TRIBAL COLLABORATIVE to Prevent & End Homelessness

Leech Lake Mille Lacs Red Lake White Earth

December 14, 2022

Re: Letter of support for new category, Housing, for tribal encounter rate

The Minnesota Tribal Collaborative, which consists of staff from six northern Ojibwe tribes (Bois Forte, Fond du Lac, Leech Lake, Mille Lacs, Red Lake and White Earth) who are working to prevent and end homelessness, is in support of Governor Walz requesting the Minnesota Legislature to direct the Minnesota Department of Human Services to submit to the Centers of Medicare and Medicaid Services a new category of Housing for the tribal encounter rate. Homelessness including doubling up, substandard housing and overcrowded conditions are a serious and seemingly intractable problem on many Reservations. Across Minnesota, Native Americans are disproportionately experiencing homelessness. The Minnesota Tribal Collaborative was formed to apply for funding, continue working and creating the resources necessary to end homelessness on Indian Reservations for Native Americans throughout Minnesota.

The Minnesota Tribal Collaborative is currently receiving state funding (DHS and MN Housing) to prevent and end homelessness on and off reservations. Housing Stabilization Services is a Medicaid reimbursable set of services that helps people with a disabling condition and housing instability find and keep housing. Allowing tribes to bill this set of services as an encounter rate would increase reimbursements for the tribes and allow tribes the flexibility to use increased resources for non-Medicaid reimbursable services such as outreach and shelter services. Currently two tribes, Red Lake and Bois Forte, are successfully billing Medicaid for Housing Stabilization Services and White Earth is almost done with the provider enrollment process. In Minnesota, American Indians are far more likely to experience homelessness than any other racial or ethnic group and this disparity has worsened during the pandemic. We believe the tribal encounter rate would provide tribes the flexibility and income to decrease homelessness amongst our relatives and increase healthy outcomes.

The Minnesota Tribal Collaborative is ready and willing to support the Minnesota Department of Human Services in requesting this new category as we believe it could be transformative in ending homelessness on and off the reservations.

Sincerely,

Tammy Moreland

Tammy Moreland
Chair, Minnesota Tribal Collaborative

Nova L. Harrison

Nova Harrison
Vice Chair, Minnesota Tribal Collaborative