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Connecticut Housing Engagement and Support Services (CHESS) Initiative

Frequently Asked Questions (FAQ)

Please note that this document will be updated on a rolling basis.

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Overview

Q. What is this initiative all about?

A. We are proud to announce that Governor Lamont's proposed coverage of a supportive housing benefit in Connecticut Medicaid, as well as associated funding for housing vouchers, were included in the biennial budget enacted by the legislature.

A multi-disciplinary team composed of state agencies (the Departments of Social Services (DSS), Mental Health & Addiction Services (DMHAS), Housing (DOH), and Developmental Services (DDS), as well as the Connecticut Housing Finance Authority (CHFA)) and private partners (the Connecticut Coalition to End Homelessness, the Corporation for Supportive Housing, and the Partnership for Strong Communities) is working on model design and will be seeking feedback from a broad array of stakeholders, in anticipation of implementing this new benefit later this year. This effort is called the Connecticut Housing Engagement and Support Services (CHESS) initiative).

The intent of the evidence-based Medicaid supportive housing benefit is to improve housing stability and health outcomes for an identified group of Medicaid members who have complex health conditions, have experienced homelessness, and tend to cycle through use of the hospital emergency department, inpatient admission, and in some cases, short-term nursing home stays, resulting in high Medicaid costs. Implementing the benefit under the Medicaid State Plan will enable Connecticut to gain federal Medicaid matching funds and to achieve cost savings in the state budget.

This initiative reflects the fact that Connecticut has historically had the benefit of a significant portfolio of state-funded supportive housing, two privately-funded supportive housing pilots, and experience with a "housing plus supports" model used for many years under the state's Money Follows the Person (MFP) initiative. The clear learning from past efforts is that transition and tenancy-sustaining supports have been found to be effective at achieving housing stability as well as improved health, community integration and life satisfaction for people served by Medicaid.

Important Background

Q. Why is Medicaid covering supportive housing services?

A. The Center for Medicaid and CHIP Services (CMCS) has become increasingly conscious over time of the need to meaningfully address social determinants of health (notably, housing stability) and to clarify what services can be covered under Medicaid. CMCS was motivated both by progress under, but also need for sustainability planning in support of, the federal Money Follows the Person program. It was also influenced by state-funded work in supportive housing.

In June, 2015, CMCS issued new policy guidance on Medicaid coverage of "transition services" and "tenancy-sustaining services," which is available at this link:

https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-06-26-2015.pdf

The guidance outlines a range of Medicaid authorities (e.g. State Plan, waiver) under which these services may be covered.

Q. How does CMCS define supportive housing services?

A. As detailed in the above policy guidance, CMCS defines terms as below. See page 5 for more detail on Connecticut's proposed service array.

Transition services are defined as:

- Conducting a tenant screening and housing assessment that identifies the participant's preferences and barriers related to successful tenancy.
- Developing an individualized housing support plan based upon the housing assessment that addresses identified barriers and participant goals.
- Assisting with the housing application process.
- Assisting with the housing search process.
- Identifying resources to cover expenses such as security deposit, moving costs, furnishings, adaptive aids, environmental modifications, moving costs and other one-time expenses.
- Ensuring that the living environment is safe and ready for move-in.
- Assisting in arranging for and supporting the details of the move.

- Developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized.

Tenancy-sustaining services are defined as:

- Providing early identification and intervention for behaviors that may jeopardize housing, such as late rental payment and other lease violations.
- Education and training on the role, rights and responsibilities of the tenant and landlord.
- Coaching on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy.
- Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action.
- Advocacy and linkage with community resources to prevent eviction when housing is, or may potentially become, jeopardized.
- Assistance with the housing recertification process.

Q. Why did Connecticut pursue this option?

A. Too often, we have observed that people who are unstably housed, or experience homelessness, and are served by Connecticut Medicaid, have poor health outcomes and rely almost exclusively on the emergency department for their medical needs. Lack of stable housing and access to preventative care often entirely intercepts their ability to effectively manage chronic conditions such as diabetes, and fails to address co-occurring medical and behavioral health needs. Connecticut has implemented a significant portfolio of state and grant-funded supportive housing, but has not historically covered this set of services under Medicaid.

Q. What's the evidence for these expected results in Connecticut?

A. The CHESS work group members reviewed the results of two pilots funded by private philanthropy (FUSE and SIF) and experience under MFP and concluded that supportive housing services and rental assistance have a direct link to increasing use of preventative care and reducing acute care for individuals who are poor, have complex medical and behavioral health needs, and do not have stable housing. Additionally, state partners identified that use of tenancy-support services for high cost and high need individuals can result in significant health care cost savings.

Q. Who is leading development of the Medicaid Supportive Housing Benefit?

A. A multi-disciplinary team composed of state agencies (the Departments of Social Services, Mental Health & Addiction Services, Housing, and Developmental Services, as well as the Connecticut Housing Finance Authority) and private partners (the Connecticut Coalition to End Homelessness (CCEH), the Corporation for Supportive Housing (CSH), and the Partnership for Strong Communities) is working on model design for CHESS and will be seeking feedback from a broad array of stakeholders, in anticipation of implementing this new benefit later this year.

Target Population

Q. How was the target population identified?

A. A match between statewide Medicaid claims and Homeless Management Information System (HMIS) data was conducted through a partnership between DSS, CCEH, CSH and New York University. The results of this match were used to identify a cohort of high need, high cost people who experience homelessness and typically cycle through costly Medicaid-funded inpatient care (hospital admissions, and in many cases, short-term nursing home placements).

Q. What were the match criteria?

A. The match of Medicaid claims data and Homeless Management Information System data that was conducted by New York University used two match criteria: Medicaid eligibility and any occurrence in shelter during the 12-month period from October 1, 2017 through September 30, 2018.

Q. Will additional targeting criteria be added?

A. Yes. The CHESS workgroup is making recommendations on further targeting, which could be premised on the following: 1) particular services; 2) the intensity of the care plan; and/or 3) the dollar value of a care plan. This could include criteria such as serious and persistent mental illness, co-occurring medical and behavioral health conditions, frequent use of the emergency department and/or inpatient hospital services, and /or length or pattern of homelessness.

Q. How will people be selected and contacted about these new services?

A. The data match has identified a group of people who have experienced homelessness, have complex health profiles and have high annual Medicaid costs. State partners are identifying processes through which people will be identified, contacted, assessed and connected with services. This will take into account current processes including, but not limited to, the Coordinated Action Networks (CANs) which coordinate access to homeless services in Connecticut.

The Proposed Benefit

Q. What will Medicaid cover?

A. The CHESS team will be conducting outreach to providers to gather further input on the types of services to be included. Proposed services fall into the categories of 1) Pre-Tenancy and Tenancy Supports; and 2) Rehabilitative, Life Skills and Care Coordination Services:

Pre-Tenancy and Tenancy Supports

- Targeted Outreach and Engagement
- Independent Assessment
- Case Management and Care Plan Development
- Housing Coordination and Tenancy Supports

Rehabilitative, Life Skills and Care Coordination Services

- Crisis Intervention
- Therapeutic Rehabilitative Skills Development
- Medical Care Services Coordination
- Behavioral Health Services Support
- Income, Employment, Education and Vocational Activities
- Transportation
- Support Groups
- Peer Supports

Q. How will services be defined?

A. In some cases, there are already standard definitions available and in use by DSS for the above services (e.g., for MFP and the Medicaid home and community-based services (HCBS) "waivers"). Existing definitions will be used in all cases in which it is feasible.

Q. How will the benefit be funded?

A. Based on the expected outcomes and cost-savings associated with the proposed benefit, Governor Lamont proposed – and the enacted budget for the biennium includes – funding for the 1915(i) State Plan Amendment. Under this amendment, Connecticut will receive matching federal funds on Medicaid expenditures. Based on cost analysis of the targeted population, the 1915(i) benefit is expected to reduce total Medicaid expenditures by $2.7 million in FY 2020 and $13.9 million in FY 2021.

Q. What housing resources will be available?

A. DOH and CHFA have identified existing housing vouchers for potential leverage to be paired with the Medicaid benefit under DSS. The budget also included funding for new vouchers.

Assessment and Referral

Q. How will individuals be assessed and referred?

A. The state agencies are developing a workflow for this process. Currently, the plan is to start by working through a conflict-free assessment entity (i.e., an entity that does not also provide supportive housing services) to contact and determine the needs of individuals identified in the data match. Ongoing, refreshes of the data match will likely identify additional eligible people. Individuals who agree to accept services will be given an opportunity to choose a Medicaid-

enrolled provider of supportive housing services and, if needed, to receive housing supports through the applicable Coordinated Access Network.

Proposed Provider Requirements

Provider Qualifications and Participation

Q. What qualifications must providers have to provide and claim for these services?

A. Provider qualifications will be finalized and published by the CHESS workgroup.

Q. Will providers have to enroll as Medicaid providers?

A. Yes. DSS and its Medicaid Management Information System (MMIS) contractor, DXC, will support providers in enrolling and learning about Medicaid processes. DXC has considerable experience supporting entities that have not traditionally been enrolled in, or claimed reimbursement under, Medicaid to do so. Examples include homemaker/companion agencies and autism providers. What has been typical of the process is to set up recurring meetings with providers at which a list of issues and concerns is developed, to develop an FAQ and other technical assistance documents that are updated on a rolling basis, to hold in-person and virtual training sessions for both leadership and direct staff, to implement call center support functions, and to remain available for ongoing support. The process for enrolling as a Medicaid performing provider is now entirely electronic and is guided by both wizard support and also real-time live assistance, as needed.

Reimbursement Rates

Q. How will reimbursement rates be set?

A. In some cases, Medicaid already has rates for proposed services. Where new rates must be developed, the DSS Certificate of Need and Reimbursement Unit will be doing so. Ongoing, all rates will be published in a publicly available file.

Implementation Plans

Stakeholder Process

Q. How will the work team seek feedback on proposed plans for the benefit?

A. Over the course of late summer and early fall 2019, the work team will connect with stakeholder groups including, but not limited to, the Reaching Home groups, the Medical Assistance Program Oversight Council, the Behavioral Health Program Oversight Council, federally qualified health

centers, Money Follows the Person Steering Committee, the Connecticut Hospital Association, supportive housing tenants, Keep the Promise, Regional Behavioral Health Action Organizations and ACT Focus Groups to seek feedback on the proposed targeting criteria for participants, service array, provider credentials and other features of model design.

Medicaid Authority Process

Q. What is a 1915(i) State Plan Amendment and why is it being used to create this benefit?

A. Below is a brief overview of 1915(i) State Plan Amendments:

Authority	**Features**
1915(i) State Plan Amendment (SPA) 1915(i) is a longstanding section of the Social Security Act that was liberalized and improved under the Affordable Care Act. Connecticut currently uses a 1915(i) SPA to cover older adults in the Connecticut Home Care Program for Elders who meet income and resource rules, but historically could not meet functional eligibility criteria.	A **SPA** option through which states can: • cover home and community-based long-term services and supports for target populations who require less than an institutional level of care • cover care management and home and community-based services • waive comparability [the requirement that services for all Medicaid recipients be provided in the same amount, duration and scope] and income rules [enabling the state to use a higher income limit than is typically authorized for community-based individuals - equal to 300% of the Supplemental Security Income benefit] **Note: States cannot waive statewideness or cap participation under a 1915(i)**.

DSS has chosen to use a 1915(i) SPA because:

- It permits the state to build on efforts that have historically been funded with federal grants and state dollars by including the services that they cover under the Medicaid State Plan and gaining federal Medicaid match;
- It permits coverage under Medicaid, but also enables the state to limit eligibility for services based on targeting criteria;

- It enables the state to contract with supportive housing providers as Medicaid-enrolled providers and to process claims for their services through the Medicaid Management Information System;
- The state has already successfully used a 1915(i) to target, and gain federal match, for a small number of older adults who were financially, but not functionally, eligible for the Medicaid waiver component of the Connecticut Home Care Program for Elders (elder waiver); and
- The 1915(i) is an efficient SPA vehicle that uses a template and, unlike waivers, does not typically require extensive negotiation with the Centers for Medicare and Medicaid Services (CMS).

Q. What is the application and approval process for a 1915(i) State Plan Amendment?

A. The State Medicaid agency (DSS) must submit a SPA to CMS for review and approval in advance of implementing a 1915(i) HCBS benefit. To do so, states must use a template document that requires check off of a range of features of the 1915(i) related to target population(s), financial and functional eligibility criteria, proposed service array and income rules. If the state is targeting the benefit to one or more target populations, CMS will review and approve the 1915(i) for a period of five years. CMS approval can then be renewed for successive five-year periods.

Timeframe

Q. What is the timeframe for implementing the new services?

A. All state partners are committed to a process that carefully considers feedback from a wide variety of stakeholders, through channels including groups such as the Money Follows the Person Steering Committee and Reaching Home. There are many technical details still to be confirmed. The Medicaid authority process itself will likely take several months. The best current estimate is that this initiative will be implemented in late fall of 2019.

Quality Assurance and Evaluation

Q. How will the performance of the initiative be evaluated?

A. The aims of the initiative are to achieve housing stability as well as improved health, community integration and life satisfaction for the Medicaid members who will be served. We will partner with a third-party evaluator to evaluate progress in these areas.

Q. How will individual outcome measures be selected?

A. The CHESS workgroup will select measurable performance objectives. Providers will have an opportunity to comment on these during provider sessions and through written feedback.

Q. How will quality assurance for these services be handled?

A. The CHESS workgroup will set quality assurance standards for this benefit. As the state Medicaid agency, DSS will draft and publish audit guidelines, and perform quality assurance activities, including periodic audits, ongoing.