



Connecticut Housing Engagement and Support Services (CHESS) Initiative

Medical Assistance Program Oversight Council

October 9, 2020



- Governor Lamont's policy recommendation to cover supportive housing benefit under Medicaid, was included in the biennial budget passed by the GA
- What is now known as the **Connecticut Housing Engagement and Support Services (CHESS)** initiative has two major features:
 - Funding in the DSS budget to cover the **state match for Medicaid supportive housing services** to up to 850 people
 - Funding in the DOH budget to cover **345 state-funded housing vouchers**, as well as **support for an additional 505 people through federal housing subsidies**.



- CHESS implements June, 2015 guidance from the Centers for Medicare and Medicaid Services (CMS) [<https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-06-26-2015.pdf>] on Medicaid coverage of “transition services” and “tenancy-sustaining services” that outlined a range of Medicaid authorities under which these services may be covered
- In using Medicaid funding, CHESS is a means of achieving sustainable funding for supportive housing services in Connecticut



- CHES is premised on our collective observation that **transition and tenancy-sustaining supports provided through DMHAS-led Connecticut supportive housing, pilot programs and Money Follows the Person** have historically been instrumental in helping Medicaid members to achieve housing stability and also improved health, community integration and life satisfaction
- CHES also acknowledges the need to **build on DMHAS and DOH's extensive experience**, as well as to use a **public-private partnership**, to inform this work



- To this end, **state agencies** (the Departments of Social Services, Mental Health & Addiction Services, Housing, and Developmental Services, as well as the Connecticut Housing Finance Authority and the Office of Policy and Management) and **private partners** (the Connecticut Coalition to End Homelessness, the Corporation for Supportive Housing, and the Partnership for Strong Communities have collaborated on model design, with strong input from many other **stakeholders, including people with lived experience**



- Beacon Health Options, the behavioral health administrative services organization (ASO), has performed many vital functions in development of CHES, notably including extensive data analytic work
- Beacon will serve as the lead CHES operational partner, with responsibilities including:
 - Development of model design
 - Outreach to locate and engage members who are homeless
 - Clinical assessment for services
 - Coordination with Supportive Housing Providers
 - Authorization of services



- CHES is fundamentally **premised in data**
- Targeting of the individuals who are being prioritized for CHES services and housing vouchers is being informed by the following:
 - Matching Medicaid claims and data from the Homeless Management Information System (HMIS) on a monthly basis
 - Use of comorbidity index scores that **predict future illness** to select people most likely to benefit from CHES, with improved quality of life and reduction in avoidable Medicaid spending



- Finally, the CHES model design **advances health equity**
 - comorbidity index scores were carefully reviewed to ensure equity
 - this is in contrast to many other models nationwide that have relied on past claims data - we now recognize that this method is inherently biased because health care utilization is often lower among members of racial and ethnic minority groups



- On behalf of the working group, DSS has been holding a series of advance discussions with CMS on CHES and is close to informal sign-off
- We are targeting December 1, 2020 as the prospective CHES implementation date, contingent on:
 - Final approval of state agency leadership
 - Submission to (required by statute) and briefing of the committees of cognizance
 - Formal submission of Medicaid authority documents to CMS, and timely approval



- Extensive preparatory work is ongoing, including:
 - Refinement of operational workflows and related tasks in partnership with Beacon and DSS Medical Operations Team
 - Tasks needed to enable CHES in DSS eligibility and case management systems
 - Plans for further engagement with and training of providers (CHES benefit, development of care plans, skills building around the Medicaid claiming process)



- CHES is projected to serve up to 850 people

- CHES has **four eligibility requirements** - individuals must:
 - Be **homeless or have been homeless prior to admission to an institution** (e.g. skilled nursing facility);
 - Have a **behavioral health diagnosis**;
 - Have a specified minimum **comorbidity index score**; and
 - **have two “critical needs”** (e.g. need for assistance in maintaining housing stability, need for assistance with medication administration)



- **CHESS will target outreach** to individuals who:
 - are identified through ongoing matches of Medicaid and Homeless Management Information System (HMIS) data (homelessness);
 - have a high comorbidity index score, which predicts future illness severity; and
 - have a significant number of days in shelter based on HMIS

- Individuals identified through the above method, who choose to apply for CHESS, will be assessed to confirm that they have at least two critical needs



- As noted previously, Beacon Health Options is overseeing major program functions, including data match, outreach, assessment and referral to supportive housing providers
- CHES will limit provider participation to those that have been selected by DMHAS under its supportive housing services procurements
- Providers will receive support for enrollment as Medicaid providers as well as programmatic training



- **Key components of CHES include:**
 - **Person-Centered Recovery Plan Development** – development of the person's care plan
 - **Pre-Tenancy Supports** - assistance in locating and securing stable housing
 - **Tenancy Sustaining Supports** - assistance in maintaining successful tenancy (healthcare coordination, skill development and community integration)
 - **Transportation** - assistance with increased access to community supports (e.g. employment)
 - **Housing Subsidies** - provided by DOH



Pre-Tenancy Supports

Pre-tenancy Supports assist the person in moving from homelessness, higher level of care, or risk of homelessness into housing in the community. Services are aligned with the participant's goals as documented in the participant's person-centered recovery plan (PCRP).



Tenancy-sustaining supports

Tenancy-sustaining supports help the participant maintain tenancy once housing is secured. Ongoing housing-related services, in addition to other long-term services and supports, promote housing success, foster community integration and inclusion, and develop natural support networks.



- In support of CHESS, DSS will be submitting **four Medicaid authority documents** to CMS:
 - A **1915(i) State Plan Amendment (SPA)**, which:
 - establishes CHESS as a new Medicaid State Plan home and community-based services benefit under the Connecticut Medicaid State Plan
 - Outlines all major programmatic features (assessment and evaluation, provider qualifications, needs-based criteria, targeting criteria, person-centered planning process, service components and definitions, quality improvement strategy, eligibility groups, and reimbursement methodology)



- **A separate SPA that creates a new optional eligibility group** for people receiving CHESS services, who are eligible for, but not receiving 1915(c) waiver services
- **An Alternative Benefit Plan (ABP) SPA** that adds CHESS to the package of services for which HUSKY D (Medicaid expansion group/low-income adult) members are eligible
- **A 1915(b)(4) waiver** that enables Connecticut to limit participation to supportive housing providers that have already been selected by DMHAS through procurement



- CHES is built on a 1915(i) SPA because:
 - it permits the State to gain federal Medicaid match on services that have historically been primarily covered by federal grant and General Fund dollars
 - it authorizes coverage under the Connecticut Medicaid State Plan, but in contrast to the typical requirement that services be available on a comparable basis to all members, enables the State to use targeting criteria



- it enables the State to enroll supportive housing providers and to pay them through the Medicaid Management Information System
- the State has already successfully used a 1915(i) for a small number of older adults under the Connecticut Home Care Program for Elders
- it is an efficient SPA vehicle that uses a template and does not typically require extensive negotiation with CMS



Appendix:

Background on Connecticut Supportive Housing and Money Follows the Person



- **Permanent Supportive Housing** is defined as affordable housing + individualized supports

- **Individualized supports** include:
 - Case management and peer support
 - Employment supports
 - Daily living skills
 - Social and family connections
 - Access to medical, behavioral health and substance use care, and recovery orientation



- Connecticut supportive housing work is led by an Interagency Council on Housing and Homelessness
- Supportive housing is funded through:
 - development funding by the CT Housing Finance Authority and the Department of Economic and Community Development
 - rental subsidies by the Departments of Housing and Mental Health & Addiction Services
 - supportive services by the Departments of Children & Families, Mental Health & Addiction Services, and Social Services



- **Demonstration Program** – 281 units in 9 projects in 6 communities, development, combines Low-Income Housing Tax Credit (LIHTC) and HUD-funded Rental Assistance
- **Permanent Supportive Housing** – development and scattered site, approximately 2,500 vouchers statewide to house individuals and families experiencing homelessness who have behavioral health disorders, combines LIHTC, Section 8, Rental Assistance, Rental Assistance Program (RAP)



- 8 regional **Coordinated Access Networks** (CANs) are responsible for coordinating entry into homeless and housing services
- Connecticut observes a **Housing First** approach that prioritizes rapid access to permanent rental housing under a standard lease agreement, as opposed to mandated therapy, treatment or service compliance



Two targeted projects have shown very promising results in linking supportive housing to improved health outcomes:

- **CT Collaborative on Re-Entry (formerly, FUSE)**
 - program targeted individuals with mental illness or chronic substance abuse, who cycled through homeless service and justice systems
 - involved matching of Department of Correction and Homeless Management Information System data
 - grew from 30 to 190 units in three counties



■ Social Innovation Fund

- program targeted individuals who experienced homelessness and who had greater than \$20,000 in annual Medicaid costs
- involved matching of Medicaid and Homeless Management Information System data
- involved 150 RAP vouchers as well as 10 vouchers from various other housing subsidies and served four counties



What is “rebalancing”?

Rebalancing refers to reducing reliance on institutional care and **expanding access to community-based Long-Term Services and Supports (LTSS).**

A rebalanced LTSS system gives Medicaid beneficiaries **greater choice in where they live and from whom they receive services.** It also delivers LTSS that are **integrated, effective, efficient, and person-centered.**

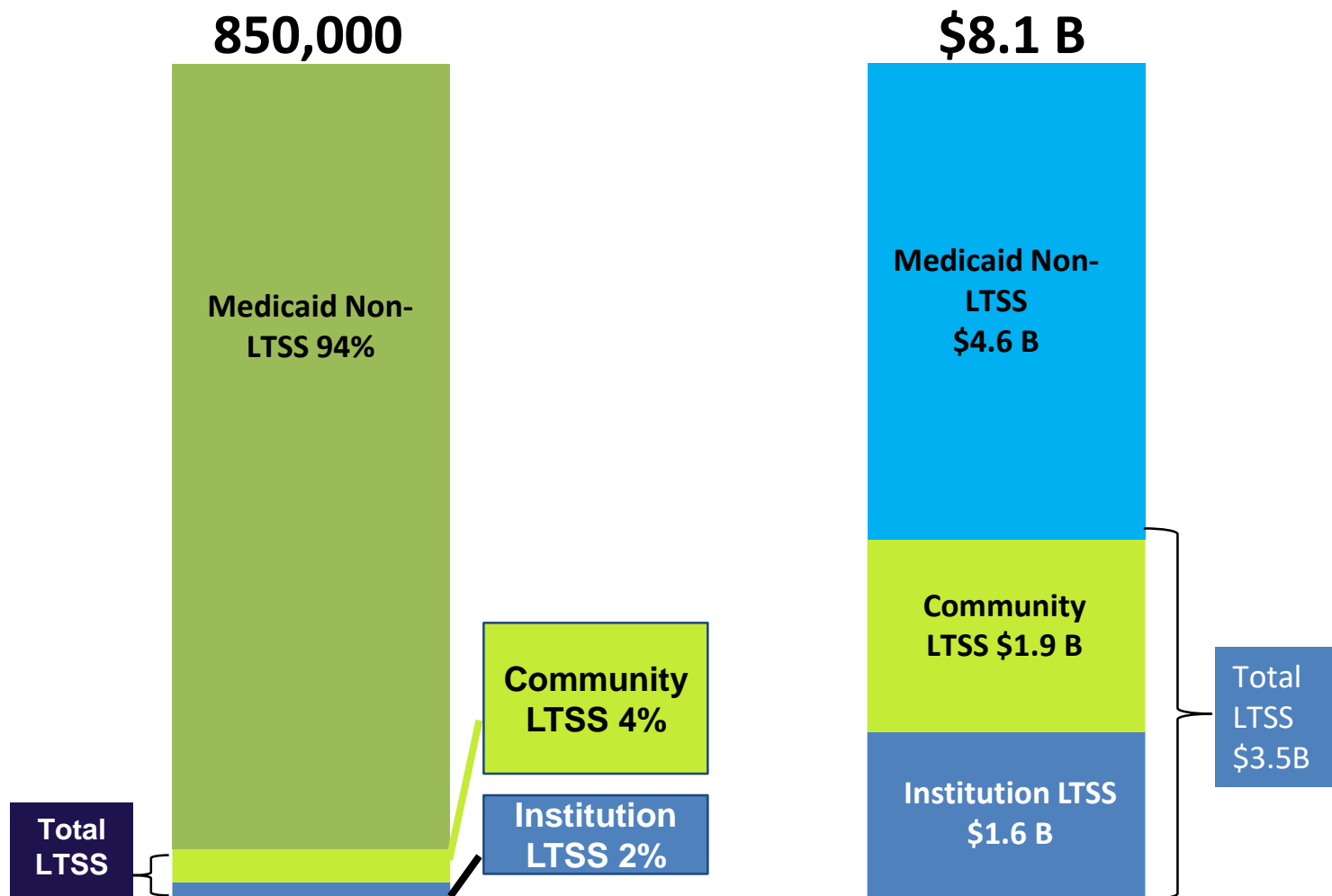


Why rebalance the system?

- **Consumers overwhelmingly wish to have meaningful choice** in how they receive needed LTSS.
- In Olmstead v. L.C. (1999), the Supreme Court held that Title II prohibits the unjustified segregation of individuals with disabilities. **Medicaid must administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.**



- A relatively small number of individuals use LTSS, but their **costs are a significant proportion of the Medicaid budget.**
- Individuals who use LTSS typically have **high needs and high costs** and **benefit from coordination** of their services and supports.
- Average per member per month **costs are less in the community.**





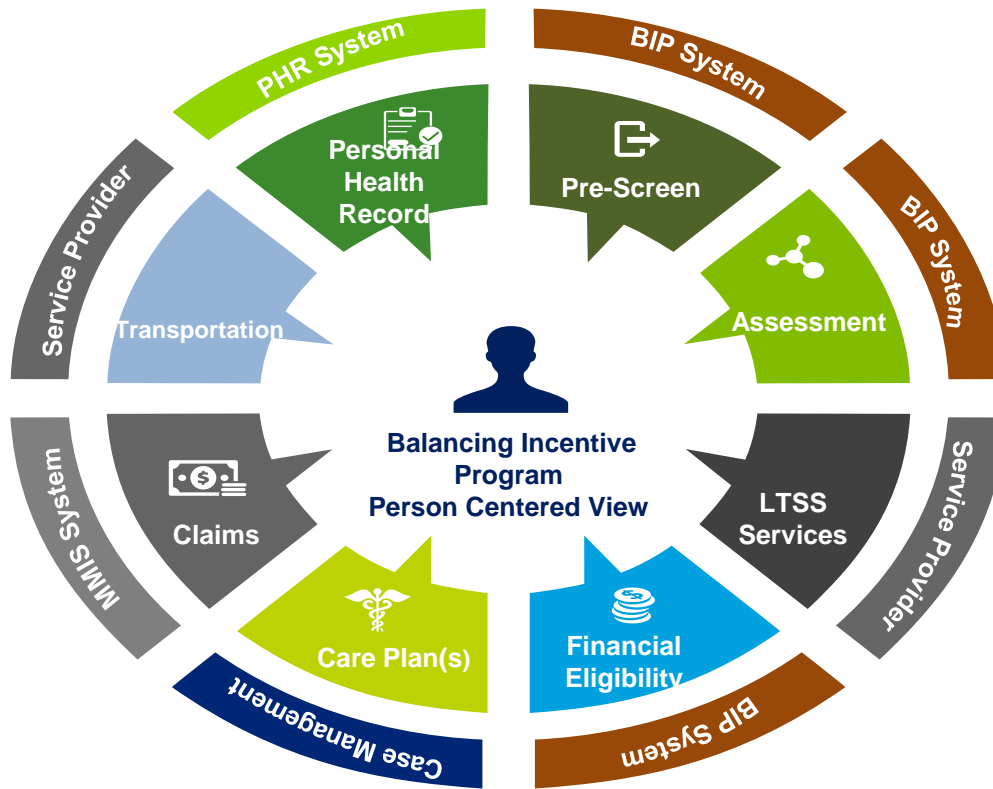
- **People have historically faced barriers** in Medicaid to receiving community-based LTSS
 - lack of sufficient services, supply, and information
 - inadequate support for self-direction and person-centered planning
 - lack of housing and transportation
 - lack of a streamlined process for hospital discharges to the community
 - lengthy process for accessing Medicaid as a payer
 - lack of a sufficient workforce



- The rebalancing agenda is **enabling access to affordable, accessible housing**.
- Connecticut's Money Follows the Person (MFP) model is a unique **“housing plus supports” model** under which people receive both services and housing vouchers.
- Both MFP and Medicaid waivers also support **accessibility modifications** to housing.



- We have transitioned over 6,300 individuals from nursing facilities to the community under MFP.
- This figure has continued to increase year over year.
- In FY 20, we served 64% of individuals who receive Medicaid LTSS in community settings, and spent 52% of Medicaid LTSS dollars on home and community-based services.
- **We have proven results concerning integration and life satisfaction for individuals who have transitioned.**



Achievement of a person-centered, integrative, rebalanced system of long-term services and supports

