Updated May 12, 2021

Connecticut Housing Engagement and Support Services (CHESS) Initiative

Frequently Asked Questions (FAQ)

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

FAQ Contents

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), Department of Housing (DOH), and Department of Developmental Services (DDS), as well as the Connecticut Housing Finance Authority (CHFA)) 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 and continually seeking feedback from a broad array of stakeholders, in anticipation of implementing this new benefit in the summer of 2021. 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 room, inpatient admission, and in some cases, 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 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 outlined 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 pp. 6-9 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 going to the emergency room 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. This lack of housing stability and lack of effective chronic disease management may lead to institutionalization. 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 is 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 continue to seek feedback from a broad array of stakeholders, in anticipation of implementing this new benefit later this year. Beacon Health Options was selected as the operational partner. DSS is responsible for the administration of the program.

Model Design

Q. How was the model design developed?

A. A match between statewide Medicaid claims and Homeless Management Information System (HMIS) data was conducted through a partnership between DSS, CCEH, CSH and Beacon Health Options. The results of this match were used to identify a cohort of Medicaid-eligible people who experience homelessness and typically cycle through costly Medicaid-funded inpatient care (hospital admissions and, in many cases, nursing home placements). Data was further analyzed to identify people who had certain diagnoses that were deemed 'high risk' and likely to result in high healthcare utilization. To be eligible for CHESS, applicants must meet this 'high risk' threshold.

Q. What were the match criteria used for the model design?

A. The match of Medicaid claims data and HMIS data was conducted by Beacon Health Options and includes individuals with any occurrence in shelter during the prior 90 day period. Beacon Health Options will refresh the match monthly.

Q. How will people be selected and contacted about these new services if they are in the matched data set?

A. The data match has identified a group of people who have experienced homelessness, have complex health profiles and meet the high-risk threshold. State partners are identifying processes through which people will be identified, contacted, assessed and connected with services. This will consider current processes, including, but not limited to, the Coordinated Action Networks (CANs) which coordinate access to homelessness services in Connecticut. The group identified through the data match will be targeted for intensive engagement and outreach with the aim of encouraging an application to the CHESS program.

Q. If people are not in the data set, can they still apply for CHESS?

A. Yes. Individuals who are not in the data set may apply for services under CHESS. These individuals must meet the evaluation criteria to be eligible. Evaluation criteria are defined in the following section labeled 'Evaluation Criteria for Eligibility Determination'. Since the data set is limited to individuals who were in a shelter, there may be individuals who meet HUD criteria 1 or 4 who are not in the data set.

Q. Is there a general target criteria that applicants must meet?

A. Yes. All applicants must be age 18 or over the age of 18 and must also have a mental health or substance use disorder diagnosis. These criteria must be met before an applicant is evaluated for eligibility.

Evaluation Criteria for Eligibility Determination

Q. What is the eligibility criteria?

A. **Critical Needs: Each participant must have at least 2 critical needs (defined below) and risk factors.**

Critical needs are defined as need for hands-on assistance or cueing with one or more of the following activities of daily living (ADLs) or instrumental activities of daily living (IADLs):

- Bathing
- Dressing
- Eating

- Toileting
- Transferring
- Meal Preparation
- Shopping
- Medication Management
- Healthcare Coordination
- Transportation
- Housework
- Managing Finances
- Maintaining Housing Stability
- Behavioral Health Management

Risk Factors: Each participant must also have the following risk factors, each of which are is further defined below:

Risk Factors: In addition to meeting at least two critical needs, each participant must also have the Homelessness and Medical and Behavioral Health Comorbidity risk factors, each of which is further defined below:

o **Homelessness:** Currently at risk of meeting the definition of homelessness without the receipt of 1915(i) CHESS services, which is determined in part based on a history of having met the definition of homelessness or have met the definition of homelessness not more than 12 months prior to current institutionalization (regardless of how long the individual has been living in the institution)

Homelessness is defined as category 1 or category 4 of the HUD definition of homelessness in 24 C.F.R. § 583.5:

- Category 1 describes situations in which an individual living in a place not intended for human habitation, living in a homeless shelter or other similar arrangement, or is exiting an institution after less than 90 days and immediately before entering the institution was living in a shelter or place not intended for human habitation; or
- Category 4 describes situations in which an individual is fleeing or attempting to flee domestic violence or other specified situations, has no other residence, and lacks the resources or support networks, to obtain other permanent housing; and

o **Medical and Behavioral Health Comorbidity**: The individual is at risk of further medical and/or behavioral health needs, as demonstrated by a score of not less than 4 on the Charlson Comorbidity Index, as supplemented with behavioral health indicators from the Elixhauser Comborbidity Index (together, the “Modified Charlson Comorbidity Index”), which is a measure of a high degree of medical and/or behavioral health comorbidity.

Q. Why are ADLs considered critical needs for CHESS eligibility when CHESS services do not include hands-on assistance for ADLs?

A. ADLs are part of the foundational assessment for all Medicaid long-term supports and services.

Proposed Benefit

Q. What will Medicaid cover?

A. Proposed services fall into the categories of (1) Pre-Tenancy Supports; (2) Tenancy Sustaining Supports; (3) Transportation; and (4) Care Plan Development and service planning

Pre-Tenancy Supports

Pre-tenancy supports provide direct support to the participant in order to 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) and include the following:

- Conducting a tenant screening and housing assessment that identifies the participant's preferences and barriers related to successful tenancy. The assessment includes, to the extent applicable to the participant, identification of potential housing transition barriers, as well as identification of housing retention barriers;
- Assisting participant with development of an individualized housing support plan based upon the housing assessment that addresses identified barriers, including short and long-term measurable goals for each issue, establishes the participant's approach to meeting the goals, and identifies when other providers or services may be required to achieve the goals;
- Assisting participant to find and lease an apartment and assistance with tenancy issues and problems;
- Assisting participant with obtaining voucher and security deposit applications, apartment search, lease compliance education, assistance with tenant inspection, and lease signing;
- Assisting participant with negotiating landlord/neighbor relationships and understanding and maintaining rights of tenancy;
- Assistance in obtaining required ID;
- Assisting with the housing application process and housing search process;
- Assisting participant with apartment inspection;
- Assisting participant in arranging for and supporting the details of the move;

- Assisting participant with transition from homelessness, higher level of care, or risk of homelessness, including assistance with planning for returning to community life by assisting with moving, timely access to services, medication and benefits;
- Assisting participant with making applications, including access to utilities and essential items and resources to move into a new home;
- Assisting participant with development of a person-centered housing support crisis plan that includes prevention and early intervention services when housing is jeopardized;
- Assisting participant with provision of therapeutic, rehabilitative and skills development;
- Assisting participant with obtaining income, employment, education and vocational activities as defined in the PCRP, including use of SSI/SSDI Outreach, Access, and Recovery (SOAR); and
- Assisting participant with behavioral/medical health coordination.

Services are preauthorized for up to 180 days in 15 minute units. Ongoing authorization beyond the initial pre-authorization is tailored based on the individual's needs. This service cannot be provided at the same time as tenancy sustaining supports. Providers must deliver direct services monthly. Direct services are services directly for the benefit of the participant. Services must be documented in the DSS case management system.

Tenancy Sustaining Supports

This service is made available to support participants to maintain tenancy once housing is secured. The availability of ongoing housing-related services, in addition to other long-term services and supports, promotes housing success, fosters community integration and inclusion, and develops natural support networks. Tenancy sustaining supports include the following:

- Providing early identification and intervention for behaviors that may jeopardize housing, including late rental payment and other lease violations;
- Education and training on the roles, 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;
- Assisting in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action;
- Providing advocacy and linkage with community resources to prevent eviction when housing is, or may potentially become, jeopardized;
- Assisting with the housing recertification process;
- Coordinating with the tenant to review, update and modify their housing support and crisis plan monthly to reflect current needs focused on maintaining their housing and addressing existing or recurring housing retention barriers; and
- Continuing training in being a good tenant and lease compliance, including ongoing support with activities related to household management;
- Ongoing support and coordination of benefits

- Therapeutic rehabilitative skills development
- Income, employment, education and vocational activities
- Health coaching and wellness education
- Coordination of behavioral and medical health services

Providers must provide direct services monthly. Direct services are services directly for the benefit of the participant. Services must be documented in the DSS case management system.

This service is pre-authorized for up to 365 days at a 15 minute unit rate. Ongoing authorization beyond the initial pre-authorization is tailored based on the individual's needs. This service cannot be provided at the same time as pre-tenancy supports.

Transportation

Mileage reimbursement is payable under this service when the provider utilizes their own vehicle to provide the transportation described below for the participant. Transportation includes mileage reimbursement and bus passes for transportation related to goals defined in the PCRP, including:

- Travel to appointments with a participant and/or transportation to access community services, activities and supports;
- Assistance with transition, including transportation for the participant as needed, to move back to the community if hospitalized or in residential treatment, including gaining access to waiver or personal care services; and
- Transporting a participant or providing bus passes to support the participant to be self-employed, work from home (for work-related travel required to maintain work from home) or perform work in a community-based setting.

Goals associated with transportation must be clearly defined in the PCRP. Authorization for transportation must be defined in the PCRP.

Monthly bus passes may be provided instead of, or in addition to, mileage reimbursement described above, but may not duplicate a bus pass provided for non-emergency medical transportation (NEMT).

Care Plan Development and Service Planning

This service includes completion of the supportive housing assessment and the development of the service plan. The service is payable after approval of the service plan and submission of a claim.

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.

Q. What housing resources will be available?

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

For CHESS participants who transition to the community after 60 days of institutionalization, Money Follows the Person housing subsidies will be used.

Assessment and Referral

Q. How will individuals be assessed and referred?

A. Individuals will be assessed by Intensive Care Manager (ICM) located at Beacon Health Options. ICMs are behavioral health clinicians. These clinicians will use the state's Universal Assessment to determine the individual's functional needs and will review other eligibility criteria related to homelessness and hospitalizations.

Reassessment of the individual's functional needs and review of other eligibility criteria is required on an annual basis for all CHESS participants.

Proposed Provider Requirements and Reimbursement

Provider Qualifications and Participation

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

A. Provider qualifications are as follows:

- Master's degree in social work, rehabilitation counseling, psychology, counseling, or other behavioral health, counseling program or other helping profession;
- Bachelor's degree in social work, rehabilitation counseling, psychology, counseling or other behavioral health counseling program and a minimum of one-year experience working in a health care or behavioral health care or related community-based setting;
- Graduation from an accredited college or university with an Associate's degree in one of the helping professions, including social work, human services, counseling, psychiatric

rehabilitation, psychology, criminal justice and a minimum of two years working in a community-based behavioral health or related setting;

- High school diploma/equivalent and minimum of three years working in a community-based setting; or
- Peer Specialist with one-year experience in a community-based self-help or behavioral health setting. Years of lived experience (i.e., personal experience with homelessness and/or living in recovery) can be used in lieu of education.

In addition, staff must participate in training as required by DSS and must use the DSS case management system.

Q. Will the providers have a role in the assessment and service planning process?

A. Yes. The development of service plans will be based on both a clinical assessment and a supportive housing assessment. Beacon will complete the clinical assessment. A supportive housing provider will complete the supportive housing assessment and will develop the service plan with the participant taking both the clinical assessment and the supportive housing assessment in consideration.

Q. Will the provider be permitted to assign completion of the supportive housing assessment and development of the service plan to the same employee who provides ongoing supportive housing supports?

A. No. The provider will be required to assign the responsibility for assessment and development of service plan to an employee other than the employee who assigned to provide ongoing support. The same employee cannot complete the service plan and also provide supports.

Q. Will providers have to enroll as Medicaid providers?

A. Yes. DSS and its Medicaid Management Information System (MMIS) contractor, Gainwell, formally known as DXC, will support providers in enrolling and learning about Medicaid processes. Gainwell 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 support ongoing. 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. The DSS Certificate of Need and Reimbursement Unit will establish rates. Ongoing, all rates will be published in a publicly available file. The current proposal for rates includes a 15 minute unit rate. Rates are still under negotiation with CMS. The reimbursement also includes a pay for performance incentive aimed to achieve 1) a housing search and lease-up that takes 6 months or less from the time a homeless individual is assigned to a provider; and, 2) improved health outcomes once the individual is housed.

Provider Training

Q. Will training be available for providers?

A. Yes. Training in 5 core areas will be available at 2 different intervals every 12 months. Training will include learning opportunities for: 1) motivational interviewing; 2) supervision; 3) person centered planning; 4) supportive housing supports; 5) substance use. Completion of all 5 core training opportunities is required within the first 12 months for each staff person participating in CHESS. Training will also be provided to support provider enrollment and the claiming process. This training will be conducted by Gainwell, DSS' contractor responsible for the Medicaid Management Information System. All training is anticipated during the 4 weeks prior to the CHESS start date.

Implementation Plans

Stakeholder Process

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

A. During the 2021 calendar year, the work team will continue to 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. Here 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) State Plan amendment because:

- It permits the State to leverage federal grants and state expenditures 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) 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 time frame 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. Our best current estimate is that we will be implementing in the summer of 2021.

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 serviced. We will partner with UConn Health, Center on Aging, to evaluate progress in these areas.

Q. How will individual outcomes 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.

APPENDIX

CHESS Questions from Service Provider Engagement Meeting

December 9, 2020, Updated February 1, 2021

Q: Can you clarify the information about being a DMHAS housing provider and who is selected for this project?
A: If your agency is currently funded by DMHAS to provide supportive housing services and was awarded these funds through the DMHAS competitive process (RFP), the agency can become a CHESS provider so long as it also meets the specific provider requirements for CHESS. To become a CHESS provider, the agency must enroll with the Department of Social Services to provide services under Medicaid. Enrollment training will take place approximately 4 weeks prior to the program start date.

Q: If a person has been homeless in the last two years but not in a nursing home, but is inadequately housed and needs more support to risk future homeless will they qualify?
A: Eligibility for CHESS is based on 4 criteria. One of the criteria is based on risk of homelessness without receipt of CHESS services.

Q: The vast majority of people in need of these services have never been in a nursing home. Why has this been included?
A: There are people in nursing homes who were homeless prior to admission. These individuals do not have a 'safe' discharge plan without housing and CHESS services. For that reason, they were included.

Q: What if, for confidentiality reasons, information cannot be put into HMIS? Domestic Violence for example
A: If confidentiality prevents the entry of information into the HMIS, the state will use alternative strategies to evaluate eligibility. For example, for those people fleeing domestic violence, the state plans to coordinate with domestic violence shelters and people can self-refer, if they feel they meet all eligibility criteria.

Q*:* Is it the state's choice to make this so narrow or is this being directed by the Feds? The more rigid the definition the less helpful it will be to a larger population of those who need support and housing.
A: Eligibility is not directed by the Federal government. Due to limitations in available state resources (both for state share of Medicaid payments and also limited numbers of state-funded housing vouchers) eligibility criteria was developed to target resources to those people who are most at risk for unnecessary hospitalizations and health decline due to unstable housing. If CHESS is successful in significantly reducing avoidable Medicaid spending over time for participants, then it is possible that the state could consider broadening the criteria at some point in the future.

Q: How is someone entered in HMIS if they are unsheltered? **A:** There is increased outreach to people who are unsheltered and people can self-refer, if they feel they meet all eligibility criteria and documentation requirements are fully satisfied (which seeks third-party information whenever available).

Q: Will Beacon provide direct services under this initiative? A slide mentioned direct outreach to shelters etc.

A: No, Beacon will not provide direct services under CHESS. Beacon will engage in outreach to a targeted group of individuals who appear eligible based on the data match, which is part of Beacon's administrative functions as the Medicaid program's behavioral health administrative services organization (ASO). The purpose of outreach is to engage people in applying for CHESS, not to provide direct services. Once an individual applies for CHESS, Beacon does not have a service related role related to the CHESS program.

Q: Are these referrals bypassing the CAN/HPC system?
A: The CAN is the reliable network for affirming homelessness status. CAN data uploaded into the HMIS will be used as the primary evaluative criteria for homelessness. CHESS has dedicated housing subsidies so eligibility for the CHESS program has no negative impact on priority under the by-name list. People who receive CHESS may be on the BNL and therefore the CANs should be informed when the person is housed.

Q: Do you have an estimate of how many people will be eligible?
A: Based on current available data, the state plans to serve 850 people over 3 years.

Q: Since this is a Medicaid program, will these plans need to be approved by the providers' physicians?
A: While evaluation for eligibility may include verification of certain information from a physician, the physician is not required to approve the person-centered recovery plan. The plan is developed by the supportive housing provider with the CHESS participant and then submitted to Beacon for approval. Specific staff qualifications for both the CHESS providers and Beacon assessment staff are detailed in the CHESS proposed Medicaid State Plan Amendment (SPA).

Q: What's the rationale for separating assessment/goals and service provision?
A: Federal Medicaid requirements applicable to CHESS require that the service types and the amount of service that an individual receives are aligned with the goals of the person and are provided based on a documented need. In addition, federal Medicaid regulations also provide specific conflict of interest protections for all individuals who receive 1915(i) services (which includes CHESS). For that reason, the person who completes the housing assessment and the service plan cannot be the same person who provides the services, as well as other conflict of interest protections that will be detailed in the SPA and other materials. This is because the service plan documents the types of services that are appropriate and the amount of time that service will be provided each week. Ensuring that the person who develops the plan and the person who provides the service are 2 different people, prevents the possibility that a plan is 'conflicted' by interests of the provider.